HEALTH CARE REFORM
(Part 5)

HEARINGS

BEFORE THE

SUBCOMMITTEE ON

HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON

ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

NOVEMBER 4, 1993—ROLE OF THE STATES
NOVEMBER 8, 1993—COST CONTAINMENT
NOVEMBER 18, 1993—IMPACT ON MEDICARE
NOVEMBER 19, 1993—IMPACT ON MEDICAID AND LOW-INCOME PEOPLE

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HEALTH CARE REFORM

Role of the States

THURSDAY, NOVEMBER 4, 1993

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, DC.

The subcommittee met, pursuant to notice, at 11:02 a.m., in room 2123 Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. If you will kindly take your seats, we want to get started with our hearing.

This morning we continue our hearings on the administrative structure of President Clinton's health care reform plan. Two days ago, we heard testimony on regional alliances, the new institutions that the President has proposed to increase the purchasing leverage of small- and medium-sized firms. Today we will focus on existing institutions, the States, and their new authority under the President's plan.

Some of the witnesses we have heard have criticized the President's plan for creating new national and regional bureaucracies and vesting too much regulatory authority in them. But a careful reading of the bill suggests that the President actually proposes to concentrate most of the regulatory power and authority not in the National Health Board, not in the regional alliances, but in the States.

Under the President's plan, the States will decide whether they want to participate in health reform and, if so, on what terms. They will be able to establish single-payer programs and they will be able to establish managed competition programs. If they choose managed competition, they will define and establish the regional health alliances.

In either case, they will be able with the approval of the Secretary to take over Medicare within their borders. They will have exclusive responsibility for certifying health plans, for monitoring the quality of care in those plans, and for enforcing consumer protections regarding quality and access. With a few exceptions, the standards that States use in certifying and monitoring plans will be their own. The States will also implement insurance and medical practice reform.

In short, what we have here is a proposal for a dramatic expansion in State regulatory power and flexibility that is intended to and most certainly will produce wide variation from State to State.

The question for today's hearing is whether that expansion and the variation that will result are consistent with a Federal guarantee for universal access to comprehensive benefits.

There are, of course, other issues that the bill raises with regard to the role of the States, the most important of which concern the proposed changes in Medicaid and the impact of those changes on program beneficiaries and on the States. This is a major issue that the subcommittee will explore at a separate hearing later this month at which Mr. Vladeck has agreed to appear.

Before calling our first witness, I would like to recognize the distinguished ranking minority member, Mr. Bliley, for his remarks.

Mr. BLILEY. Thank you, Mr. Chairman.

Today's hearing examines the effects of the President's health care plan on the States, the role of the States in regulating the alliances in health care plans and the State option to embrace a single-payer system. I think it is no exaggeration to say that the States over the past 5 years have already been key players in both Federal health care and budgetary policy through the Medicaid program. In some instances, they have been unwilling recipients of Federal Medicaid mandates which have single-handedly done more damage to State budgets than any other Federal program, and many of these mandates originated from this committee.

In this regard, I would like to remind everyone that former Governor Clinton endorsed both the 1989 National Governors Association resolution which asked for a moratorium on any new Federal Medicaid mandates and when Congress ignored that resolution, the 1990 National Governors Association resolution which actually asked for a rollback of Medicaid mandates that were part of OBRA 1989. On the other hand, the States have also participated in some of the most creative accounting and financing schemes of all time in their innovative use of provider taxes and disproportionate share payments. This is a program that grew in less than 2 years from less than $1 billion to $17 billion annually. That is why I would like to especially welcome today's guest, Bruce Vladeck, the current HCFA administrator.

Mr. Vladeck, in his position as the administrator of the Health Care Financing Administration has one of the pivotal roles in evaluating the effects of the administration's Health Security Act on the States. As the HCFA administrator, he is the top government official with direct authority over the day-to-day operations of both Medicare and Medicaid. In that position, he has a special responsibility to guarantee that Medicare and Medicaid beneficiaries do not end up with inferior health care benefits after the enactment of any health reform proposal.

And it is my strong belief that, based on this standard, he may have already spent many sleepless nights contemplating the $198.7 billion of cuts in the Medicare and Medicaid program, which are key elements of the President's program. Lest we forget, these are unprecedented, Draconian entitlement cuts coming on the heels of approximately $60 million in entitlement cuts in the 1993 reconciliation bill.

First, I would like to make some comments about Medicaid. Under the Clinton plan, regional alliances will receive from the State and Federal Government payments which will amount to

only 95 percent of what would have been paid out if these cash eligible beneficiaries were still on Medicaid. Second, the Clinton plan places a very stringent CPI cap on Medicaid payments for these beneficiaries.

This cap will cut spending for these beneficiaries by over $22 billion over 5 years. Clearly the alliances are going to have to make up the differences through assessments on health plans or higher premiums. In fact, these two provisions must lead to Medicaid's traditional financial magic trick: Cost shift to get private sector to make up the Medicaid shortfall.

Medicare is also exposed to the budgetary guillotine to the tune of $123.4 billion over 5 years. This cut allows some $56 billion in Medicare reductions made in reconciliation this year. Moreover, the future of the Medicare program under the President's plan is unclear because both the single-payer option and regional alliances States can force all their Medicare beneficiaries into the health care—State health care system.

And when States opt out of Medicare, Federal payments will be capped at CPI. The individual Medicare beneficiary will not have a choice. Simply put, the States that opt out of Medicare, the elderly will lose their Federal benefits for a capped State-run benefit.

Additionally, the President's plan requires that States maintain that current level of spending for Medicaid and other State health programs. The State maintenance of effort requirement triggers a host of complicated issues. While some States have taken advantage of optional Medicaid eligibility categories, other States have not. Also, some States have relatively rich Medicaid benefit packages. Consequently, States that have more generous Medicaid programs will have to maintain much higher levels of State payments than others. The administration's plan will freeze these differences into place. Clearly, this issue must be examined closely.

Finally, the administration's plan will have monumental redistributional effects on States. The distribution of subsidies will vary greatly by the number of uninsured in the State and the number of low wage workers. We look forward to Mr. Vladeck's testimony and his views on those issues.

Thank you, Mr. Chairman. I apologize for the length of the opening statement.

Mr. WAXMAN. Thank you very much, Mr. Bliley.

Mr. Cooper, do you have an opening statement?

Mr. COOPER. Are we allowed to have opening statements, Mr. Chairman?

Mr. WAXMAN. Well, it is up to you.

Mr. COOPER. If I could make a few short points.

Mr. WAXMAN. You could wait until the questions and then give your speech.

Mr. COOPER. I really just wanted to ask one question, but I will wait for the question period, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Mr. Chairman, I do have an opening statement. I will be very brief.

It seems to me that a true litmus test for a good national health reform bill is that it encourage innovative health solutions at the

State levels. In recent years, some of the freshest thinking about health reform has in fact come at the State level.

Washington, D.C. was caught up in partisan sniping, for example, but my own home State of Oregon had the bipartisan guts to do what no other political body has done in this country, and that is make tough choices about the health care priorities of our Nation. We have also seen innovative approaches used in Florida, Minnesota, and other States.

So it seems to me that an absolute prerequisite for successful national health reform, particularly through this subcommittee which has a unique relationship to State health programs, is that we ensure that this legislation makes it possible for States that have been innovative to be rewarded and not be punished for their groundbreaking work.

This is an especially important hearing, Mr. Chairman. I look forward to our witnesses.

Mr. WAXMAN. Mr. Upton?

Mr. Greenwood, any opening statement?

Mr. GREENWOOD. No.

Mr. WAXMAN. Mr. Klug.

Mr. KLUG. Thank you, Mr. Chairman. If I can amplify Mr. Bliley's concern that under the administration's plan, a number of States like Wisconsin, my home State, which has very generous benefits packages, may find itself locked into a corner where it can't paradoxically reduce Federal benefits but at the same time finds that some of the matching payments now directed at Wisconsin is repackaged and shipped off to other States in the form of block grants.

I can tell you that I and a number of other folks in the Midwest who tend to have very good social service nets are deeply concerned about the financial penalties of the President's plan in our part of the country.

Mr. WAXMAN. Thank you, Mr. Klug.

Mr. Synar. Mr. Brown.

Our first witness this morning is Bruce Vladeck, the administrator of the Health Care Financing Administration. One of Mr. Vladeck's responsibilities is administering the $88 billion in Federal Medicaid funds which paid for 57 percent of the cost of medical and long-term care for some 34 million poor Americans.

Mr. Vladeck brings a wealth of experience to our hearing this morning. In addition to running Medicaid, the largest of the Federal grant-in-aid programs to the States, and Medicare, he has served in State government, served as a director of a large public hospital system, presided over the United Hospital Fund in New York, and served as a member of the Prospective Payment Assessment Commission advising Congress on Medicare hospital reimbursement. He is widely respected for his analytic contributions to the health care debate over the past decade.

Mr. Vladeck, we want to welcome you to our subcommittee hearing today. Without objection, your written statement will be included in the record in full. We would like you to proceed.

Ordinarily, we ask witnesses to stay within a 5-minute period. If you need a little longer because you have a lot more to cover, we will extend to you a little bit more time.

Mr. VLADECK. Thank you very much, Mr. Chairman.
Mr. WAXMAN. But not much more.

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY LARRY LEVITT, SPECIAL ASSISTANT

Mr. VLADECK. I appreciate that and the admonition as well.

I am very pleased to be here this morning. As you know, I have had the privilege of appearing before this subcommittee on other occasions in the past, but it is a particular privilege and source of some excitement to me to be able to appear before you to talk about the President's proposal for the national Health Security Act.

I am accompanied this morning by Mr. Larry Levitt and Mr. Gary Claxton, both of whom are on the staff of the Department of Health and Human Services, each of whom has played a very important role in the formulation of the President's proposal and in the development of the proposed legislation, and who are with me in case members of the subcommittee should ask any hard questions to tell me what the correct answers are.

The President's Health Security Act envisions a partnership between the States and the Federal Government that has been carefully constructed to take advantage of the resources and expertise of each in order to ensure every American the most efficient and highest quality health care possible.

The six principles of the President's plan—security, savings, quality, simplification, choice, and responsibility—can be attained through the cooperation and initiative of the three levels of entities that comprise the infrastructure of the Health Security Act: the Federal Government, the States, and the health alliances. Each of these have separate and important responsibilities defined in the act, and I know you have had considerable discussion already of the role of the alliances.

Under the Health Security Act, the Federal National Health Board will serve as a kind of steering committee ensuring that each State has a workable strategy to meet Federal standards. The board will oversee a Federal framework for comprehensive reform. That framework will establish a uniform benefit package, determine premium caps, rates of increase and enforcement mechanisms, develop insurance market reforms, and set quality standards for the States to incorporate into their systems. It will also oversee the provision of Federal assistance to make it possible for all States, even those with low per capita income and large numbers of part-time and unemployed workers, to achieve universal coverages.

States will have a great amount of flexibility to work within this Federal framework to design systems that work best for their residents. While the Federal Government will establish the framework for reform under the Health Security Act, the States will take primary responsibility for developing their own health systems that meet these requirements.

The President's proposal identifies a number of specific responsibilities for the States, and if I may just call your attention for a minute to the chart over there in the corner of the room, one that we have recycled for a variety of purposes, but the middle column

of bullet points describes the principal characteristics of the State roles. The Federal and alliance roles are also defined briefly and it may be helpful to serve as a reference during the course of this morning's discussions.

Let me very quickly summarize the responsibilities of the States. They will be responsible for implementing systems for universal enrollment and for the collection of premiums. They will have the primary responsibility for assuring that all individuals have access to a health plan that delivers the nationally guaranteed comprehensive benefit package.

States will design, establish and oversee many aspects of the regional health alliances in order to ensure that the needs of their citizens are best met. The States will be required to establish alliance areas that meet several important criteria. Those areas must encompass a population large enough to ensure the alliance's market share to negotiate effectively with health plans. No geographic area may be assigned to more than one alliance and every area of the State must be included in the alliance. The entire portion of a metropolitan statistical area located in a State must be included in a single alliance.

Finally, but not least importantly, in establishing boundaries for alliance areas, the State may not discriminate or encourage discrimination on the basis of race, ethnicity, language, religion, national origin, socioeconomic status, disability or perceived health status. The States will also be responsible for certifying health plans to participate in the alliances in very much the same way that States certify insurance policies today. Each State will need to establish a mechanism to assess the quality of health plans and their financial stability and capacity to deliver the benefit package in their markets.

In doing so, the States will be required to implement insurance reform such as mandatory open enrollment and guaranteed renewability. They will also be responsible for ensuring that the plans meet federally established coverage standards such as the elimination of preexisting condition limitations as a reason to deny or limit coverage and guaranteeing that all Americans will be covered.

The States will also ensure alliances apply the risk adjustment mechanisms established by the National Board. The States, as they now do, will operate a guaranty fund to provide financial protection in case health plans become insolvent. Finally, the States will assist the alliances in administering the subsidies for low-income individuals, families, and employers and in carrying out their data collection responsibility.

The State's flexibility to design its own system will extend even beyond these parameters. States may also choose who opt out of the regional alliance structure defined in the President's plan and instead implement a State-wide single-payer system in which the State will pay all providers directly.

A State single-payer system must still be a payroll based method that requires no less of employers than a regional alliance system. States that choose a single-payer approach must provide, at a minimum, the health services defined in the comprehensive benefits package without requirements for coinsurance, copayments, deductibles or out-of-pocket limits greater than those permitted for

regional alliance health plans. The single payer systems also must comply with requirements for cost control, quality management and improvement, the collection of health data, and other guidelines for health plans and alliances.

Mr. Chairman, each month we delay reforming our health care system costs the country an enormous amount of resources that could be spent more productively in other sectors of the economy. In the interests of our country's financial well-being, the administration hopes to work with Congress to quickly enact this plan.

If negotiations and passage can be completed this coming spring, States can begin implementation of the new system as early as October 1st, 1995. All States will enter the new system by January 1, 1998. In preparation for that transition, each State will submit a blueprint for implementing alliances and instituting requirements for employers and individuals to obtain coverage. Federal planning grants will help support development of these blueprints.

Once a State has enacted legislation to become a participating State, a grant will be made available to it to assist in establishing a regional alliances. Because of State health care reforms that are already under way, to which several members have already referred, some States could be ready to implement the plan very quickly while others, of course, will take longer.

We fully expect that the States will be eager to do what is required to provide health security for their citizens, but the Health Security Act has built-in disincentives for States that do not comply with the Federal requirements. First, penalties will include a reduction in the amounts the Federal Government pays in that State for academic health centers, for medical education training programs, for health research activities, and for hospitals in the State which serve vulnerable populations.

And for States which hesitate still in implementing the plan, the Federal Government will assume the responsibility for establishing that State's health alliances and charge a 15 percent premium surcharge to pay the costs of Federal administration. States will, however, be permitted to assume or resume their responsibilities as soon as they are ready to do so.

After a State establishes its alliances, enrolls its population and demonstrates that its new system is functioning and effective, it can request a waiver to include Medicare beneficiaries in the population covered under the health alliances.

In order for the Secretary of the Department of Health and Human Services to approve this waiver, the State must be able to guarantee that Medicare beneficiaries will have the same or better benefit coverage than the Federal Medicare program now offers. In addition to guaranteeing coverage and quality, States must also be able to ensure that Federal financial liability is not increased.

We are committed to continuing high quality, reliable coverage for the elderly and disabled and we intend to scrupulously review these waivers to protect their health care. Under the Health Security Act, older Americans will see little difference in where, how, or from whom they receive their health care. They will see a major expansion in their choices for health care with a wider range of preferred provider networks and HMO plans than ever before, along with a prescription drug benefit.

As several of you already pointed out, States have struggled for years with the soaring costs of Medicaid. The result of those cost increases have driven States to have fewer resources to expend on elementary secondary and higher education, transportation, community development, or other important State purposes.

The new partnership created by the President's plan will benefit everyone, including the States. The Health Security Act will provide increased opportunities for low income individuals and financially for the States. Medicare recipients will be integrated into the State's alliance system. Those currently on Medicare will choose their insurance coverage just as everyone else in the community does. And just as private sector employers will make payments for the health coverage costs for their employees, the Medicaid program will make payment to the alliance to purchase coverage to cash assistance recipients.

As for other participants, the annual rate of increase in the cost of coverage for the comprehensive benefit package services for Medicare recipients enrolled in the alliance will be constrained by caps on the premium growth. These payments will be shared by the States and Federal Government under current Medicaid matching arrangements and the savings will be similarly shared.

With reform of the health care system, the need for Medicare and Medicaid disproportionate share payments to hospitals to help cover charity care and other uncompensated care costs will decline. Nevertheless, Medicare disproportionate share payments will continue at a reduced level for hospitals with a significant percentage of low income patients.

The Health Security Act will also expand and improve long-term care across the country, emphasizing home and community-based services administered by the States. For these services, Federal funding will be capped with the Federal Government paying from 75 to 95 percent of program costs. Medicaid community-based care will continue as it is today.

Mr. Chairman, the States' role in the President's plan is critical to its success. We are counting on the States to create an environment for reform and to organize their resources to quickly implement a tailored system within national parameters. We already know that many States are capable and enthusiastic about implementing cost-effective reform to provide guaranteed health care to all of their residents.

We can build a national health care system that meets the needs of both State and Federal Government in accessibility, quality, cost containment, accountability, and communications while ensuring that the health and welfare of individual citizens and our society as a whole are met.

We very much look forward to working with members of this subcommittee to formulate this final legislation and to implement this plan. Thank you very much.

[Testimony resumes on p. 20.]

[The prepared statement of Mr. Vladeck follows:]

STATEMENT OF

BRUCE C. VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I'm pleased to have the opportunity to appear before you today to discuss a very important aspect of the President's Health Security Act: A partnership between the States and the federal government carefully constructed to take advantage of the resources and expertise of each so that together we may assure every American the most efficient and highest quality health care possible.

As we are all witnessing, States have been making significant headway in reforming health care to expand access, improve quality, and control costs for their residents. The President's plan enables us to take advantage of this experience as we reform the country's health care system.

The six principles of the President's plan -- security, savings, quality, simplification, choice and responsibility -- can be achieved through the cooperation and initiative of the three entities that comprise the infrastructure of the Health Security Act: the federal government, the State governments, and the health alliances. Each of these components have separate and important responsibilities defined in the Health Security Act.

Today I will focus on the role of the State governments as outlined in the President's plan, and on how we will work with them to accomplish health care reform. I will talk about the States' specific responsibilities under the Health Security Act, the States' options for alternative reforms, and the transition process for the States. And lastly, I

will describe how Medicare, Medicaid and the new long-term care benefit will connect with this new system in order to provide high quality care for elderly, low-income, and disabled Americans.

Federal Framework

Under the Health Security Act, the federal National Health Board will serve as a steering committee, ensuring that each States's plan has a workable strategy to meet federal standards. The National Health Board will oversee a federal framework for comprehensive health reform. This framework will establish a uniform benefit package; determine premium caps, rates of increase, and enforcement; develop insurance market reforms; and set quality standards for the States to incorporate into their individual health systems. It will also provide federal assistance to make it possible for all States, even those with low per capita income and large numbers of part-time and unemployed workers, to achieve universal coverage.

State Responsibilities

States will have a great amount of flexibility to work within this federal framework. While the federal government will establish the requirements for reform under the Health Security Act, the States will take primary responsibility for developing their own heath care systems that meet these requirements. The States will remain free to exercise significant discretion to design systems that work best for their residents.

The President's proposal identifies specific responsibilities for the States.

- The States will be required to implement systems for universal enrollment and for the collection of premiums. They will have the primary responsibility for assuring that all individuals have access to a health plan that delivers the nationally guaranteed comprehensive benefit package.

- States will design, establish, and oversee many aspects of regional health alliance activities in order to best meet the needs of their citizens. They will specify the number, size and geographic distribution of alliances, and States will also provide for selection of the members of the board of each regional alliance to ensure that alliances represent area families and businesses. Each State will ensure that all alliances offer health plans that provide the comprehensive benefit package and that each alliance enrolls all eligible persons in the geographic area covered by the alliance.

The States will be required to establish alliance areas that meet several important criteria. The area must encompass a population large enough to ensure the alliance adequate market share to negotiate effectively with health plans. No geographic area may be assigned to more than one regional alliance and every area of the State must be included in an alliance. The entire portion of a metropolitan statistical area located in a State must be included in the same alliance area. And finally, in establishing boundaries for alliance areas, the State may not discriminate on the basis of race, ethnicity, language, religion, national

origin, socio-economic status, disability, or perceived health status.

- The States will also be responsible for certifying health plans to participate in alliances -- in very much the way States certify insurance policies today. Each State will establish a mechanism to assess the quality of health plans and their financial stability and capacity to deliver the comprehensive benefit package to the proper geographic market. To protect providers and patients from insolvent plans, States will set capital standards and establish guaranty funds consistent with federal law. Only plans qualified by the State will be permitted to offer health coverage through regional alliances. In addition, States will remain responsible for monitoring health plans to ensure that they continue to operate within the federal guidelines.

- The States will be required to implement insurance reforms including mandatory open enrollment, guaranteed renewability, community rating, and financial standards for health plans. They will also be responsible for ensuring that health plans meet federally established coverage standards, including the elimination of preexisting conditions as a reason to deny or limit coverage, admitting all enrollees at the same price, and guaranteeing that all Americans will always be covered. And the States will be responsible for ensuring that each alliance applies the risk-adjustment mechanism established by the Federal government that accounts for differences in patient populations related to age, gender, family size and health status.

- Each State will operate a guaranty fund to provide financial protection in case a health plan becomes insolvent. This guaranty fund will be much like those already established in most States. If a health plan fails, the State may assess payments of up to 2 percent of premiums on other plans within the alliance to generate sufficient revenue to cover outstanding claims against the failed plan.

- And finally, the States will assist the alliances in administering subsidies for low-income individuals, families, and employers and in administering their data collection responsibilities.

Single-Payer Option

A State's flexibility to design its own system will extend even beyond the parameters I have just described. States may also choose to opt out of the regional alliance structure defined in the President's plan and instead implement a State-wide single-payer system in which all providers will be paid directly by the State.

As another alternative, a State will be able to create a single-payer system in one part of the State, while remaining parts of the State could be served through regional and corporate alliances. This option might be chosen, for example, for rural areas that do not have sufficient numbers of competing plans.

If a State chooses to establish a single-payer health system, the federal government can work with States to waive ERISA rules defining participation in corporate alliances.

A State's single payer system will still be a payroll-based method that requires no less of employers than the regional alliance system. States that choose a single-payer alternative must provide at a minimum the health services defined in the comprehensive benefit package without requirements for co-insurance, co-payments, deductibles and out-of-pocket limits greater than those permitted by regional alliance health plans. The single-payer systems also must comply with requirements for cost control, quality management and improvement, the collection of health data, and other guidelines for health plans and alliances.

Transition

Mr. Chairman, each month we delay reforming our health care system costs the country an enormous amount of resources that could be spent more productively in other sectors of the economy. In the interest of our country's financial health, the Administration hopes to work quickly with Congress to pass this plan. If negotiations and passage can be completed this spring, States can begin implementation of the new system as early as October 1, 1995. All States will enter the new system by January 1, 1998.

Each State will develop a blueprint for implementing regional health alliances and instituting requirements for employers and individuals to obtain coverage. Federal planning grants will help support development of these blueprints. States will submit to the National Health Board a plan for implementing health reform, demonstrating that their health care systems meet requirements under federal law. And once a State has enacted legislation to become a participating State, a grant will be made

available to assist it in establishing regional alliances. Because of State health care reform initiatives that are already underway, some States could be ready to implement the plan very quickly, while others will take longer.

The Department of Health and Human Services will work closely with States which are already in the process of implementing health care reforms to help them adapt their systems to meet the requirements of the Health Security Act.

States entering the new system on a fast track will have some additional flexibility in complying with federal regulations. To assure a rapid transition, the National Health Board, the Department of Labor and the Department of Health and Human Services will be authorized to issue any regulations on an interim final basis.

To reduce the potential for disruption in the health care system during the transition, the federal government will implement certain interim insurance reform measures that will take effect immediately upon passage of legislation. These measures include limiting premium increases and prohibiting insurers from dropping people or failing to renew their coverage.

We fully expect that States will be eager to do what is required to provide health security for their citizens. But the Health Security Act has built-in disincentives for States which do not comply with federal requirements. First, penalties will include a reduction in the amounts the federal government pays in that State for academic health centers for medical education training programs, for health research activities,

and for hospitals in the State which serve vulnerable populations. And for States which hesitate still, the federal government will assume the responsibility for establishing that State's health alliances and charge a 15 percent premium surcharge to pay the costs of federal administration. States will, however, be permitted to assume or resume their responsibilities as soon as they are ready to do so.

Medicare

After a State establishes health alliances, enrolls its population, and demonstrates that its new system is functional and effective, it can request a waiver to include Medicare beneficiaries in the population covered under its health alliances. In order for the Secretary of the Department of Health and Human Services to approve this waiver, the State must be able to guarantee that Medicare beneficiaries will have the same or better benefit coverage than the federal Medicare program now offers. In addition to guaranteeing coverage and quality, States must also be able to ensure that federal financial liability is not increased.

We are very committed to continuing high quality, reliable coverage for the elderly and we intend to scrupulously review these waivers to protect the elderly's health care. Under the Health Security Act, older Americans will see little difference in where, how or from whom they receive their health care. They will see a major expansion in their options for health care with more preferred provider network and HMO options than ever before. And the addition of a new drug benefit will further enhance Medicare, making it a more complete health care program for the elderly.

Medicaid and Long-Term Care

For years States have struggled with the soaring costs of Medicaid. As health care costs have increased, States have had fewer resources to devote to elementary, secondary, and higher education, transportation, or community development.

But the new partnership created by the President's plan will benefit everyone. The Health Security Act will provide increased opportunities for low-income individuals and financial relief for the States. Medicaid recipients will be integrated into the States' alliance systems. Persons currently on Medicaid will choose their insurance coverage through the alliances just as will every other individual. Just as private sector employers will make payments for the health coverage costs of their employees, the Medicaid program will make payments to alliances to purchase coverage for cash assistance recipients.

Like other participants, the annual rate of increase for the comprehensive benefit package services for Medicaid recipients enrolled in alliances will be constrained by premium caps. These payments will be shared by States and the federal government under current Medicaid matching arrangements.

With reform of the health care system, the need for Medicare and Medicaid disproportionate share payments to hospitals to help cover charity care and other uncompensated care costs will decline. Nevertheless, Medicare disproportionate share payments will continue at a reduced level for hospitals with a significant percentage of low income patients. And, under this new system, the Medicaid

disproportionate share hospital program will be replaced by a transitional Vulnerable Population Adjustment (VPA) program. The VPA program will provide federal payment adjustments directly to hospitals that serve a high proportion of low-income patients and provide non-covered services.

The Health Security Act will also expand and improve long-term care options across the country, stressing home and community-based services. Services will be expanded to individuals with severe disabilities, without regard to income or age. States will have the flexibility to design and define their community-based service systems, and may elect to offer vouchers or cash directly to eligible individuals. Individuals will pay co-insurance to cover a portion of the cost of services, based on a sliding scale set by the States. Federal funding will be capped, with the federal government paying from 75 to 95 percent of program costs. Medicaid community-based care will continue as it is today.

Medicaid institutional coverage will be expanded by giving States the option to allow unmarried residents of nursing homes and intermediate care facilities to retain up to $12,000 in personal assets and still qualify for Medicaid -- up from $2,000 today. All States will be required to establish a medically needy program for residents of nursing homes and intermediate care facilities for the mentally retarded.

Conclusion

Mr. Chairman, the States' role in the President's plan is critical to its success. We will depend on the States to create an environment for reform and to organize their

resources to quickly implement a tailored system within national parameters. We already know that many States are capable and enthusiastic about implementing cost effective reform that will provide guaranteed health care to all of their residents.

The Health Security Act was designed around the notion that the principles of health care reform can best be realized through the cooperation of State and federal governments, working with the private sector.

By reinforcing our existing relationships, we can build a national health care system that meets the needs of both State and federal governments in terms of accessibility, quality, cost containment, accountability, and communication -- while ensuring that the health and welfare of individual citizens and our society as a whole are met.

We are confident that this partnership will gain the support of the States and we look forward to working with them through the members of this Subcommittee to implement this plan.

Mr. WAXMAN. Thank you very much, Mr. Vladeck. I want to start the questioning with you by pointing out that one of the most critical policy issues in this plan is that of discrimination. As you have observed in your writings, the current financing and delivery system discriminates against certain high risk population groups—the homeless, persons with AIDS, TB positive individuals—with conditions that are expensive to treat. Low income communities as well as racial and ethnic minorities represent a disproportionate number of these populations.

The bill which the President transmitted to the Congress prohibits such discrimination. Section 12(O)(2)(b) prohibits States in establishing boundaries for regional alliances from discriminating on the basis of race ethnicity, language, religion, national origin, socioeconomic status, disability, or perceived health status.

Section 14(O)(2)(c) prohibits health plans from engaging in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of race, national origin, gender, income, health status, or anticipated need for health services.

However, I am unclear as to how and whether these prohibitions will actually be enforced. Can you tell us who is responsible for monitoring and enforcing compliance with these prohibitions?

Mr. VLADECK. Mr. Chairman, in the first instance, the National Health Board has responsibility for approving the States' plan for implementation of health care reform and then for monitoring the extent to which State implementation of their plans conforms with what they have told the Board they are going to do. The Board, which is directly accountable to the President, has the first order of responsibility for enforcing those along with other requirements.

Further, one of the things that I think was intended in the act was to create private rights of action pursuable in the Federal Courts for individuals who feel they have been discriminated against or otherwise treated unfairly or in a way inconsistent with the plan.

And as is often the case in other aspects of society, one would presume that direct access to the Federal judicial system would play a very important part in civil rights enforcement.

Mr. WAXMAN. So the Federal law print prohibits the discrimination, the States are to enforce it, and the Board is to look at the State plan.

Mr. VLADECK. To oversee the State role in implementing those requirements.

Mr. WAXMAN. Under the President's plan, participating States must establish capital standards for health plans that meet minimum Federal requirements established by the National Health Board. However, all other criteria for health plans including quality, financial stability, and capacity to deliver benefits are solely within the discretion of States. There are no minimum Federal requirements for these elements of health plan performance.

What is the rationale for this distinction? Isn't quality just as important as capital standards? Why should billions of Federal Medicaid, Federal subsidy, and even Federal Medicare funds flow to health plans that don't meet minimum Federal quality standards?

We certainly don't tolerate this undercurrent Medicaid or Medicare law with respect to managed care plans.

I understand the administration's reluctance to having the Federal Government micromanage this program, but what is the logic of the Federal Government putting the money on the stump for the States?

Mr. VLADECK. Mr. Chairman, I think the bill very clearly authorizes the National Health Board, through rulemaking processes, to establish a set of standards and criteria by which it will evaluate the State plan. It is clearly within the authority of the Board to address, through rulemaking, all the kinds of concerns you have just described.

I think the specification of the minimum capital requirements is not so much to imply by omission that the Board doesn't have oversight of any of these other issues, but rather because of a particular concern that in establishing the standards for capitalization of plans, there not be discrimination against community-based providers and networks in favor perhaps of large insurance companies with greater access to capital.

So, there was a desire in the drafting of the proposed bill to specifically address that concern about capital requirements but that is not meant, I believe, to limit the authority of the Board to establish through rulemaking a set of standards and requirements that the plans would need to meet and the States would need to enforce.

Mr. WAXMAN. What if the States aren't doing the kind of job you expected of them? They aren't following the rules of the National Board. What actions can that board or the Federal Government take?

Mr. VLADECK. Well, again, there is a graduated series of interventions called for in the proposed plan. The first instance would involve withholding of the various categories of Federal funds that flow to the health system in the State. In the worst case scenario the Federal responsibility for operating an alliance or the State system.

I should say, Mr. Chairman, that as you know, under the Medicaid program, our experience suggests that the extreme sanction is very rarely if ever invoked, but its existence and its potential use provides the Federal agency involved the opportunity to engage in negotiations with the States to ensure compliance with important program requirements. I would expect that is how it would play out under the role envisioned for the Board.

Mr. WAXMAN. Thank you.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Vladeck, currently individuals who were enrolled in the welfare programs Aid to Families with Dependent Children—AFDC—or supplemental security income—SSI—receive their health care through Medicaid. Under the Clinton plan, these individuals will be enrolled in regional alliances. The alliances will receive from the State, the Federal Government, their shares of Medicaid.

However, under the Clinton plan, the payments would amount to only 95 percent of what would have been paid if the recipients were still on Medicaid. According to John Hollahan of the Urban Institute, Federal and State governments would have paid about $27.8

billion in 1992 to provide AFDC and SSI recipients with the benefits for which they are eligible under the Clinton plan. But if the plan had actually been in service, the total payments for that year would have been $26.4 billion after the 5 percent reduction. That amounts to a $1.4 billion reduction for just 1 year.

Interestingly, this 5 percent discount does not apply to payments made on behalf of Medicaid recipients who are not on welfare. Additionally, the President's bill places the CPI cap on Medicaid spending for cash eligible individuals. We have just received revenue figures from the administration that this cap will cut an additional $22.3 billion from the Medicaid program between fiscal years 1995 and 2000. This is a cap on top of an additional $54.5 billion cut in the Medicaid program for reducing the payments to hospitals.

Given the facts that, one, Medicaid has traditionally paid physicians in hospitals less than the actual cost of treating patients; two, that welfare recipients tend to be above average in risk; and three, that AFDC and SSI recipients include the blind and disabled, women in childbearing years, and infants, all of whom tend to require more services, how can the State and Federal payments made on behalf of these individuals adequately cover the cost of providing services? Aren't the alliances going to have to make up the difference through assessments on health plans for higher premiums?

Mr. VLADECK. No, sir, we don't believe so. I think in order to understand the economic logic of integration of Medicaid recipients into the alliances, it is important to emphasize the critical nature of integrating Medicaid recipients into the mainstream system of health care. That has at least the following effects.

First of all, we already know that when we enroll AFDC recipients in the Medicaid program into well-managed care operations, we now routinely pay 95 percent of the average cost in the fee-for-service sector and many plans are able to provide high quality care for less than that 95 percent rate.

What we are talking about is integrating Medicaid population into mainstream private sector plans which will have considerable incentives to keep their costs down and therefore we think the 95 percent target is a very reasonable one to attain.

Second, I would emphasize for you that is 95 percent of the current expenditures so that the higher utilization and higher risk associated with the Medicaid population is already incorporated into that current expenditure base.

Third, it is true that, on average, Medicaid pays less to providers than private sector payers do. But by integrating Medicaid into the mainstream program, you are maintaining the same level of total revenue received by providers that is now available.

What you are doing, in effect, is increasing the proportionate amount paid on behalf of Medicaid recipients and reducing proportionately that paid on behalf of everyone else. If you did something different, you would be creating a windfall for the provider community, although we know that the average American hospital in the last several years has been as profitable as it has at any time in its history and that physician incomes, to take the examples of the two categories of providers most affected, have been growing faster than the rate of either real wage growth for everyone else in the

economy who are in inflation over that period. So, we don't think that is a problem either.

In terms of the rate of the growth, once you integrate Medicaid recipients into mainstream health insurance plans, there is no reason why costs for their care should grow any faster than it grows for everyone else in the plan.

Mr. BLILEY. Well, with a CPI cap on Medicaid currently, the program is growing at 12 percent, how is it going to keep the growth cut to 3.7 percent?

Mr. VLADECK. The same way, we believe, that the rate of the cost increase in health care expenditures in general will be cut. We hope to create a series of incentives and a new kind of market that will give both the plans and individual providers the kind of incentives to behave efficiently that they never had in the past.

Mr. BLILEY. Must be very efficient, because—I see my time is up—because you are going to be better than any country in the world if you are able to achieve that. Nobody else can, but maybe you can.

Mr. VLADECK. Well, we are talking about achieving that for a brief period of time in the course of a transition, and part of achieving that will be a very significant one-time savings in administrative costs that are critical to doing that. After the year 2000 or 2002, it is the expectation that the rate of the cost increase will go back to something more comparable to that in the rest of the world.

Mr. WAXMAN. Thank you Mr. Bliley.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Vladeck, here is the bottom line to me. It seems to me that the States are basically charged with setting up the machinery. They are going to be establishing these alliances. They are going to be certifying the plans. They are going to be identifying the individuals who are eligible for subsidies. But I don't see very much financial accountability that the States actually have. I mean, other than being accountable for the cost of their State employee health plans, and maybe there are some other things that I am not seeing, what financial accountability does a typical State have, given they are going to be out there setting up all this machinery?

Mr. VLADECK. I think the financial accountability is primarily not directly on the State Treasury but rather for the residents and employers in the State as they express their opinions and their concerns for the State political system. That is to say, rather than establishing this accountability in terms of enormous potential liabilities for the State, what we are doing is trying to establish a situation in which the States will feel the heat, as everyone else will, to maintain reasonable levels of growth in costs in order to maintain the competitive position of their employers and the relative burden for their residents.

Mr. WYDEN. Well, take a look at the statement of the National Governors Association on this point, because they say, and I quote, States will not have the tools to ensure choice of health plans at prices and premiums at or below the average premium.

So it is great to talk about somebody feeling some heat out there somewhere but the Governors are telling us that they don't have the tools to really try to drive the kind of cost containment that is

significant. I think we have got to come up with some real incentives for States to hold costs down and I would encourage you all to explore this with the Governors, because I think there is very little here that I can see that produces financial accountability at the State level.

It would be one thing if the States weren't out there basically running the machinery, but they are. Maybe you can tell us something that addresses the comment of the National Governors Association as to the tools States have to ensure adequate choice of low-cost plans?

Mr. VLADECK. Well, in terms of ensuring adequate consumer choice, I think ultimately only the consumers can do that and the consumers will choose whatever they choose. The fact is that the States will have a very much expanded responsibility in terms of regulation of plans and of the insurance market, and that the alliances in some fundamental sense are very much creatures of the State governments as well.

The proper functioning of both the alliances and the plans, which are at the heart of the dynamic of the competitive pressures to keep costs down in this system, are entirely within the control of States as envisioned in this proposal.

Mr. WYDEN. Let me ask you a question about the ERISA, the Employee Retirement Income Security Act. My State is basically ready to give care to 300,000-plus uninsured workers ahead of the administration's schedule. I think there are other States that are in the same boat.

I think it is very important that there be a process to grant limited ERISA waivers so we can get health care to those uninsured workers just as quickly as possible. Would the administration be receptive—and I am going to be introducing legislation for my State and I think others are going to for their States—would the administration be receptive to legislation that would grant immediate limited waivers assuming that they were in line with the overall standards that the administration is looking at in the ERISA area?

Mr. VLADECK. Mr. Wyden, I can't speak for the administration specifically to a prospective proposal. I can remind you we supported a proposal for such exemptions in the discussions of reconciliation earlier this year. We hope to have the Health Security Act enacted just about as soon as more special purpose legislation on this subject could be enacted and, therefore, would probably want to concentrate all our energies on the Health Security Act.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman.

Welcome to the subcommittee.

I have a problem, particularly with the ads that we have been seeing on the TV with the couple sitting at the kitchen table talking about the money that is no longer there. I would like to set up a hypothetical example, in which that could easily happen in Michigan. If the auto companies continue to lay off people as they have in the past several years, suddenly, with one quarter to go, the State of Michigan could find itself without money to continue funding for the alliance.

I could envision the Secretary of Treasury calling the director of the alliance in Michigan to say, I am sorry, the Congress has refused to raise taxes, we are not going to be able to come up with the millions of dollars that your alliance needs to finish the last quarter.

If you are the chairman or the CEO of that alliance, what do you do?

Mr. VLADECK. Well, first of all, sir——

Mr. UPTON. By law, you can't cut off health care services to the people that are entitled to the basic benefit package.

Mr. VLADECK. We think that scenario is especially improbable. I think Dr. Thorpe testified at the Senate Finance Committee to this effect last week. We modeled the macroeconomic effects of changes in the unemployment rate on the total size of the subsidies and on the Federal dollars involved in the subsidies, and I think that there is considerable cushion still within the budget that has been established to provide that.

But in that extremely improbable instance, the alliance does have the opportunity to undertake short-term borrowing from the Federal Reserve until we can reconcile all the various issues about the flow of subsidies. And so we don't think the worst case would be likely to happen. In the worst case, the ultimate risk here——

Mr. UPTON. Let me correct you on one thing. Judy Feder, when she was here earlier in the week, indicated that they could not borrow to make up for a shortfall for that purpose.

Mr. VLADECK. They obviously can't borrow if the Federal Government doesn't deliver on its subsidy, but if an alliance underestimates the amount of income it receives in premium payments from employers, that is the kind of circumstance for which that borrowing is contemplated.

But assume that is not available. The ultimate responsibilities devolves to the plans and to the providers in the plans to accept transitory reductions in income in order to ensure that the system continues to function.

Mr. UPTON. So would you say that the ad that is running is partially correct?

Mr. VLADECK. No, I don't believe it is correct at all. I think the presumption that physicians or hospitals or whatever have an entitlement to a given payment rate is implicit in that kind of advertisement. There is no such entitlement in this proposed law.

Mr. UPTON. My district is along the State line of Indiana. We have got an MSA with South Bend. We have got an MSA with Kalamazoo. There are many employees living in States that border Michigan, very much like this region, with the District as well as Virginia and Maryland.

What happens to the employees and their families, which alliance would they be lined up with: The State that they live in or the place where they work?

Mr. VLADECK. The alliance is defined by residence rather than by place of employment.

Mr. UPTON. Would people in Michigan be able to go to Indiana if there were better services there?

Mr. VLADECK. Again, it is important to distinguish between the roles of the alliance and the roles of the plan in this regard. In-

creasingly, plans operate on an interstate or multistate basis. Clearly in this region, most of them do, and our expectation is that someone who lived in northern Indiana, who worked in Kalamazoo, who would belong to the regional alliances in Indiana would probably want to opt for a plan that operated in both Indiana and that part of Michigan, and we expect many plans would.

Mr. UPTON. Thank you.

Mr. WAXMAN. Thank you Mr. Upton.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman. We are worried about new unfunded Federal mandates for the States and also the possible balkanization of America's health care system. First, on the unfunded mandate. I couldn't help but notice in the NGA testimony that will be following you say things like "because States will have no control over the budget that will be set nationally, States will not have the tools to ensure choice."

"The Governors' policy supports budget targets in the early year of reform rather than immediate enforceable premium budget caps as detailed in the Health Security Act." And it goes on. Specific concerns about the financing of long-term care. "Federal participation, though significant, is limited while State financial exposure may not be." That is the unfunded mandate question.

Another question is balkanization. Can you remind me who ran for President last year advocating single-payer health care reform in America?

Mr. VLADECK. No one who survived the primaries.

Mr. COOPER. Then why are we going to be getting it on a State-by-State basis in this bill?

Mr. VLADECK. We have a very strong sense that folks inside the Beltway, whether in the executive or legislative branch, shouldn't be dictating to citizens of a particular State how they want to organize their health systems. And those States where the folks want to have such a system, we don't know any good, compelling reason why they shouldn't permit them.

Mr. COOPER. Since about 80 percent of the American people voted for a presidential candidate last year who said they were for managed competition and we are worried that no State will be allowed to have real managed competition under the administration bill because no State will be allowed to have a tax cap for the next 10 years, no State will be allowed to have other features of managed competition. We are worried there might be a little bit of bait and switch here.

Eighty percent of the people voted for a managed competition approach and we end up with one that guarantees the ability for States to choose single payer. In fact, the roadblocks were cleared out in a recent negotiation apparently with Senator Wellstone. But no State is able to have managed competition if you consider that managed competition should have a tax cap.

Mr. VLADECK. Mr. Cooper, at the risk of perhaps getting lost in semantics, I would suggest my reading of all the poll data and all the similar data, does not convince me that 80 percent of the American public voted for a tax cap. In fact, to the extent that such a cap is necessary for the pursuit of the particular theoretical pro-

posal, we have chosen what we view as a more pragmatic and incremental approach to a more competitive health care marketplace.

Mr. COOPER. You would admit that the path is clear to single payer for any State that wants one. Could you tell me how it would work in the D.C. metropolitan area? Assume D.C. chooses single payer and assume Maryland and Virginia do not. How will that be implemented?

Mr. VLADECK. Presumably, the District government would establish a single-payer authority which would ensure coverage for all its folks, pay provider claims, and presumably have to pay claims to providers outside the District in accordance with fee schedules for out-of-plan or out-of-area use that these alliances in Virginia and Maryland would have to establish anyway.

Let me just say in response to that particular question, I think we have a special issue in terms of interstate relationships with the District and its surrounding States because of the peculiar constitutional status of the District, as well as the very high proportion of——

Mr. COOPER. Let's take a multistate system. Assume New York State goes single payer. Connecticut and New Jersey do not. How will it work there? How do you build in a national framework for a health care system with a fundamentally different approach that, again, no presidential candidate that survived last year supported is being allowed to be implemented on a piecemeal basis across our Nation.

Isn't that going to be hard to integrate into a market-based philosophy that I thought most of the candidates were supporting last time?

Mr. VLADECK. I think the differences in health care systems and financing arrangements between New York and Connecticut under a scenario in which New York had a single-payer system and Connecticut had an alliance-based system like we expect most States will establish would be no greater than there is now.

Mr. COOPER. I get no credit for foregoing my opening statement, Mr. Chairman; is that right?

Mr. WAXMAN. I am sorry. You had your chance. You can stick around for another round.

Mr. COOPER. He is tough.

Mr. WAXMAN. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. Vladeck, in section 1551 of the Health Security Act, minimum capital requirements are specified for regional health alliance plans. Section 1551(b) states that the minimum capital requirement is $500,000. Section C states that the National Board may require additional requirements, but there is no mandate that the National Board require additional capital above the $500,000 figure.

Potentially, in this new system, we could easily see health care plans enrolling tens of thousands of individuals with budgets in the hundreds of millions of dollars. To me, a $500,000 equity requirement for such large plans seems ludicrous. This is particularly true considering this committee's experience with Medicaid managed care plans.

Through Chairman Waxman's diligent work, this committee has identified many instances of Medicaid HMO's being grossly undercapitalized. This has led to managed care plan failures with the result that providers such as hospitals are owed millions of dollars. Obviously, it also has led to disruption of the medical care that Medicaid recipients receive.

To solve this problem, Mr. Waxman, at one point during this subcommittee's deliberations during the 1993 reconciliation bill, offered a provision that required for profit managed care plans to maintain a ratio of equity capital to plan contract payments of not less than one-tenth. This is a significantly more stringent standard than currently in section 1551.

Would you tell us why the President's bill set equity standards which would seem to guarantee that plans could be grossly undercapitalized?

Mr. VLADECK. Well, again, sir, as I understand it, and as Mr. Claxton has tried to educate me, in section 1515(c), we do require the States to develop risk-based capital requirements that are analogous to those suggested for for-profit managed care plans by the chairman in another context. Our expectation is that they will develop such requirements and that in most instances the requirement will be significantly higher than the $500,000.

Again, as I suggested earlier, we are very eager to discourage the States from tilting the deck or the playing field, whatever the appropriate metaphor is in favor of the largest, most well-capitalized national insurance companies. We are very eager that locally based provider networks be able to compete on a level playing field.

And to the extent that a State establishes minimum capital requirements in excess of the $500,000 threshold, we would want them to have a defensible methodology related to the risk of the characteristics of their plan in order to do so.

Mr. GREENWOOD. I would like to turn back and follow up on the questions with regard to single-payer State options. It is my understanding that if a State applies to the National Health Board to be a single payer State, they could integrate all of the Medicare beneficiaries into the regional alliances. Under those circumstances, once Medicare beneficiaries are integrated into the alliance, the Federal payments for these former Medicare beneficiaries will be capped at the same growth rate as the alliance, which is the CPI plus population growth. Furthermore, under those circumstances, individual Medicare beneficiaries would have no choice. They would be taken out of Medicare and put into the alliance.

I would just like you to comment on first, whether my assumptions and analysis are correct here and, second, how you think the Medicare population of the country is going to feel about this situation.

Mr. VLADECK. I believe your assumptions are correct but not entirely complete, sir, because in addition to limiting the growth in Medicare provider payments, or Medicare outlays to the same as that for the private sector, the proposed statute is very explicit that the State will have to guarantee and assure us that the benefits available to Medicare beneficiaries and their access to services would be at a minimum no less than if they remained in the current Medicare program.

Mr. GREENWOOD. Let me interrupt you, if I may. Wouldn't that imply, then, that if you have a Medicare population rolled into the alliance, you have got the same cap. You have a total cap on the expenditures of the alliance, but you have this caveat that the Medicare population's benefits have to be maintained regardless of the cost of those benefits. That would depress the funds available for the rest of the population and the alliance. They may have to suffer substandard benefits.

Mr. VLADECK. The alliance may not reduce benefits for other folks below those in the comprehensive benefits package either. Again, the very clear requirements and expectations in this plan are that the guarantees have to do with coverage in the benefit package. It is up to the alliances and the plans under State supervision to figure out how to do that within some reasonable economic amounts. We are confident that with the right kind of incentives, they will be able to do so.

Mr. GREENWOOD. And if they don't, the result is insolvency. I guess that is the worry. My time is all out.

Mr. WAXMAN. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I was pleased the President chose to allow States the option of establishing single-payer systems within their State. You all made some significant changes from some of the initial drafts to make it easier for States to move toward single payer.

Could you outline some of those, both disincentives that you had that you took away and perhaps incentives that you built in to—if there are incentives that you built in to allow States to choose single payer.

Mr. VLADECK. I am going to have to ask one of my colleagues to do that. If I may just say by preface to their answers, I think this was an issue where our intent was inconsistent with the original language that was discussed, and when it was pointed out by advocates for some of the States interested in doing single-payer systems, that there were hurdles we didn't know were there, we sought to remove them. I don't think there is any change in intent in terms of the specific changes in the drafting. I frankly don't remember.

Larry, can you answer that?

Mr. LEVITT. Yes. There are really a couple of big incentives and, as Bruce said, it was really a matter of just how we described the intent rather than a significant change in the policy. One was to clarify that the process for a State to enact a single-payer system did not involve obtaining a waiver from the Federal Government but rather there is a clear authority to do that in the Federal law for a State to enact a single-payer system consistent with the requirements in the act.

The second big issue was in terms of what kind of financing the State could use to fund the system. We clarified that the State could use a financing system. It had to be payroll based, but it could be different from the premium-based financing in an alliance system. And the stipulation is only that employers in that State must pay at least the amount that they would pay under an alliance-based system so that States don't compete with each other over financing arrangements.

Mr. BROWN. Some have argued that single—the alliances will get, if you will, larger and larger which will sort of inevitably lead, sort of inexorably lead to single payer in States. Some opponents and proponents of single payer have made that case, as some did sort of obliquely today talk about that.

Is that likely to happen?

Mr. VLADECK. I don't believe so. I think that comes about potentially from a misunderstanding of what the alliances are and what they do and what their role is. The function of the alliance is to act, in effect, as the agent for buyers in a world in which there will be multiple plans competing with one another.

I guess to the extent that the plans can't deliver on the promise of providing folks with high-quality services that consumers like at reasonable costs over time, there may be fewer plans available in a community and the alliances may not be able to do their jobs.

But to the extent that the incentives in the marketplace work, the role of the alliances in observing the system over time, I think, gets to be more limited, not less limited as the dynamic of competition among the plans really drives the system.

Mr. BROWN. My understanding in single payer is that States would be allowed within this framework to force, if you will, corporate alliance patients and Medicare into the single-payer system, but there is an exclusion for veterans, for military or Native Americans. Why was the exclusion done? This begs the issue of two-tiered, which is what we seem to want to avoid.

Mr. VLADECK. Let me clarify on the issue of Medicare patients; perhaps my answer to the earlier question wasn't full enough. We don't envision the States forcing Medicare patients to do anything, and I think most Members of Congress would agree with our position in HCFA that, selectively, we don't force the Medicare patients to do anything. Rather, our proposal is that if a given State is operating effectively enough, it will begin to generate choices that are very, very attractive to Medicare beneficiaries. The incorporation of Medicare beneficiaries in toto into a State plan is still something that is approved only at the discretion of the Secretary once the State meets some relatively stringent requirements.

And the scenario we envision, frankly, is not one of our pushing beneficiaries into the State system, it is one of beneficiaries banging down the door to get in and our getting out of the way.

Mr. BROWN. Last question: Any projections on how many States will do single-payer system in the next 1 or 2 years?

Mr. VLADECK. I wouldn't venture a guess. I wouldn't venture how that would evolve over time. We have had suggestions from several States they are exploring options. In Vermont, for example, they are exploring a single payers system as one of a number of options. I don't know that any State is committed down that path at the moment.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. Klug.

Mr. KLUG. Thank you, Mr. Chairman.

I want to follow up on some of the ideas that Jim Cooper explored with you. Jim and I, I guess, are advocates of a pure, managed competition model based on what the Jackson Hole folks did.

And one of the concerns I have is the definition of what the National Health Board's responsibilities are going to be and how much power is vested in it.

Now, the original Jackson Hole model, you saw a role for the National Health Board, for example, to define benefits and to monitor outcomes. So, eventually, if you had standardized plans, you could make decisions based on price and also make decisions based on quality. Here is where the confusion takes place.

When Ms. Shalala was with us a couple of weeks ago, she assured that our fears of a vast Federal bureaucracy run program were unfounded and stated that the Board would probably have 100 initial staffing it and characterized it as, quote, "a minor oversight group with some functions."

Now, you responded earlier today that essentially under the scenario in the President's plan, we could literally have three guys in briefcases land in an airport in Madison, Wis. saying we are here to nationalize your health plan.

You say the Federal Health Board will serve as a steering committee. Is it a steering committee, a minor oversight group with some functions, or is it indeed a very powerful Federal bureaucracy?

Mr. VLADECK. I think the issue of the Secretary's choice of words in terms of minor oversight body may have been beaten into the ground by now, and we tried to clarify it on a number of occasions.

Mr. KLUG. Let's give you one more time.

Mr. VLADECK. In terms of minor, she was speaking of its size and the number of employees and budget, not the scope of its responsibilities or its importance.

I think we are talking about a very small entity. We are not talking about a large bureaucracy in any sense of the word. On the other hand, there is very important Federal rulemaking and oversight contemplated in this plan and that is lodged at the Board.

In terms of net increment in Federal activities, in terms of monitoring what is going on in the States in making the rules to establish the system, we don't see that as requiring a very large bureaucracy at all. Again, understanding that much of what the Board does, it will do by drawing on the current activity, the use of existing Federal agencies.

Mr. KLUG. Let me suggest that there is quite a gap of monitoring activities of State board and essentially nationalizing State insurance which most Third World countries don't nationalize businesses anymore.

Mr. VLADECK. We are not talking about nationalizing anything, sir. What we are talking about is substituting for the States in their role of establishing alliances, of certifying plans and then letting the alliance and the plans run the health insurance market.

We are not talking about nationalizing insurers. We are not talking about nationalizing providers. We are talking about an assumption of State responsibility if the State fails to carry it out.

Mr. KLUG. I want to go back to one more clarification in this kind of dance of language we have had the last several weeks. When Secretary Bentsen and Secretary Reich were here last week, we tried to understand why the new mandated fees aren't necessarily a tax. Now we are going to mandate that an employer lay a bunch

of money on the table and we are going to mandate, A, that he has to do it, B, that it is to provide coverage, C, we also defined what he is buying and also we defined who he is buying it for.

Would you please explain to me why that is not a tax?

Mr. VLADECK. But it is not a tax. It is not being paid to the government. We mandate employers pay time and a half after 8 hours. We mandate that they pay double time on holidays, overtime for more than 40 hours. We don't count those as taxes. We mandate that they provide workmen's compensation. We don't count that as a tax. A tax is a fee paid by a citizen or corporate entity to a government. Premiums aren't taxes.

Mr. KLUG. Even if you mandate that, they have to pay them and who do they pay them to?

Mr. VLADECK. The State of Maryland requires that I have insurance on my automobile. It requires it as a matter of law in order for me to drive the automobile. I write a check to Travelers more often than I would like. I can't deduct that as a State and local tax on my Federal income tax return.

Mr. KLUG. So you disagree with Senator Moynihan's statement last week that what the Federal Government compels to pay is indeed a tax.

Mr. VLADECK. I think that is an overstatement, yes, sir.

Mr. KLUG. Thank you.

Mr. WAXMAN. Thank you Mr. Klug.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

I would like to commend the administration for presenting a bill that does embody managed competition with private nongovernment insurance companies building on a system that we are indeed familiar with. It is commendable that we have that opportunity. With the least government intrusion, that is possible and that certainly is indicated by the proposal that is being submitted by the administration.

This is in the same vein, following up on a comment by Congressman Brown about the issue of States being able to include Medicare. One State has already enacted health care reform that does include Medicare, and that is my home State of Washington.

What kind of safeguards can you give seniors in the President's proposal relative to the State option for Medicare inclusion?

Mr. VLADECK. Again, let me emphasize, sir, believe me, this is not only an issue I feel strongly about, but I have spent a lot of time working on this in the formulation of this proposal and the proposed legislation. This is not a State option.

The State has an option to request permission from the Department of Health and Human Services to incorporate Medicare into its program. And that permission will be granted only to the extent that the State is able to make and deliver on a set of assurances that we think constitute very stringent standards for the protection of beneficiaries and for the protection of the trust funds.

If States are effective at doing what many of them think they will be able to do in terms of reconfiguring their health systems and in terms of getting a handle on health care costs, then frankly, we think it would be sort of silly for the Federal Government to refuse to participate if both the government from a fiscal perspec-

tive and our beneficiaries could benefit from integration into the system.

We think that may be particularly important in predominantly rural States where Medicare is so large a part of the market for health services in rural areas and where the restructuring of provider networks is so dependent on Medicare's participation. But we have frankly, I think, written this deal to be straightforward in that we will play only if we are guaranteed that we will win.

Mr. KREIDLER. I don't know if you had an opportunity to review what Washington State has done. They will be seeking that permission that would be granted presuming they meet the criteria and standards.

Would you have any thoughts as to whether the State of Washington's proposal would meet the proposed test?

Mr. VLADECK. I must confess, Congressman, we have been so busy with the States that have already filed their waiver applications that we haven't looked at any of those that are a little bit further down the road.

I should just tell you that my own views on this subject are colored by the fact that in the early 1980's, I administered a State hospital payment system that was based on a Medicare waiver in the State of New Jersey, and we think that the integration of the Medicare payment system into the State administered system in that instance produced very significant benefits both for Medicare beneficiaries in the State and for the Federal Treasury.

So, I have some experience that predisposes me to believe that there is a lot attainable by integration of the Medicare program, but we take our responsibilities for protection of beneficiaries and the trust fund very, very seriously.

Mr. KREIDLER. OK. Another issue that Congressman Wyden brought up, relative to the ERISA waivers, is something of obvious interest in the State of Washington. Even now, as they are meeting and laying the framework, they are concerned about having that waiver in order to take in the self-insureds. For practical purposes they could not carry forward with reform without having that ERISA waiver, albeit it is included in the President's proposal.

At the same time, there is some real interest, following up on his suggestion, in any possibility of specific action for those States that are ready at the door right now. I understand in somewhat the same vein, the Department of Veterans Affairs is also showing some interest in making sure that the States like Washington, as they move forward, are able to participate early in that process rather than being delayed until the Federal implementation of health care reform.

Is there some possibility of moving forward with an ERISA waiver for some States that are really ready to go?

Mr. VLADECK. Again, Congressman, I can't speak authoritatively on an issue like that for the administration. I can tell you more generally, we think there are lots of good things in this proposal that lots of people would support individually. We also think that they all fit together really quite integrally and quite centrally, and are very much opposed to the notion of beginning to pick apart parts of this proposal piece by piece.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. I think that is an interesting point. I was going to ask a question on that myself because, in the State of Washington, I don't know what the proportion of potential participants in that risk-based pool are that will be part of corporate alliances which can be exempted. If they are pumped out of the pool, then the risk level of the pool could conceivably be considerably greater than what it would otherwise be, so I will look forward to pursuing that issue as well.

I would like to thank you for one other thing. Last week we had, and the week before, we had a number of hearings in which the financial ramifications of the plan were not clear at all. You could perhaps deduce some things from reading of the bill, but not very clearly, and at my request addressed to Ken Thorpe and Judith Feder and Secretary Bentsen, we got for the Budget Committee yesterday a very good response which I think your operation had a lot to do with preparing, and I want to thank you for that.

There are certainly some additional questions we will have behind it, but I think any serious discussion of this has got to begin with that, and I think you have done it in that case and many of the alternatives should be asked to do the same thing, because we are dealing with an enormous financial trade-off here, and having accurate figures is important to that.

In that connection, I wanted to get at one thing. As I understand it, the National Health Board in effect will set in effect the limitations on premiums and that will in some form or another have to be ratified by Congress either through budgetary action or whatever.

If those premiums are not, and I am not sure what your assumptions are in your plan, if those premiums are not allowed to increase at the true actuarial cost of those benefits, whatever they may be, I realize we are working with a moving target, you and I know that there are going to be plans that will begin to fail or there will be provider—insurers that will begin to fail, contrary to the rhetoric on the subject about the profits of insurance companies, the fact is that, in the aggregate, health care underwriters earn between something like 1.7 and 1.75 percent of premiums. And the regional health care alliances, I think, will be empowered to exact a surcharge of 2 percent on those insurers, relative to premiums, if the plan—if the alliance itself becomes insolvent.

The question I guess, I mean, that is pretty darn thin, plus the issue of capitalization ratios and so forth gets interrelated with that. Is there any—because we are discussing here States' obligations, is there any potential obligation on the State, financially, to make whole what may be deficient regional health care alliances.

Mr. VLADECK. Not as I understand it, sir. Let me begin by thanking you for the kind words about my staff and others in the administration on the numbers and then say that you are absolutely right. In any real market, some competitors are going to fail, and if we really believe that a more competitive system is central to achieving what we want to achieve in the health care system, then we have to take as an assumption and as an expectation that some plans and some providers are going to fail.

The primary mechanism through which we seek to address that is through the requirements on States to guarantee funds for the plans. This is a mechanism with which we have had a lot of experience in other forms of insurance. It has worked better or worse in certain kinds of instances where you think there are ways relative to expectations on Federal standards to certainly protect the providers and the consumers through the effective use of such mechanisms.

And, again, this is not an entirely novel notion. It has not been applied to health insurance in this way before. But we have had mechanisms of this sort in property, casualty and life insurance for many years.

Mr. McMillan. In most of those guaranty funds—we had hearings in the subcommittee—most of them have no funds, they simply have promises to pay and then if a problem arises, then the industry gets dunned. My problem is, we are creating a system here where the pressure is going to be topped down to hold the premium rate increase down. And Congress, as it will, will try to avoid responsibility for fully funding that.

So you have got an enormous downward pressure that we are saying, well, we are going to transfer that out to the risk takers out in the marketplace when in fact they operate on such a thin margin—and, again, I will say despite the rhetoric to the contrary, thin margin, even with adverse risk election being practiced, which we know needs to be corrected.

I think we are creating a situation here that may be unmanageable and that is my—one of my concerns. The Governors or the States, unless they handle financial responsibility in this, are simply going to let it ride and, as was said yesterday, it will be Congress' responsibility to react. And it was pointed out again yesterday, well it just may well react like it did to the issue of deposit insurance or any number of other things.

Mr. Waxman. The gentleman's time has expired.

Mr. McMillan. I believe that clock was a little fast, don't you, Mr. Chairman.

Mr. Waxman. It goes fast. Did you want to respond or is that just essentially it?

Mr. McMillan. That is essentially my point. If you care to respond further, with the permission of the Chair?

Mr. Vladeck. If I may, and Mr. Claxton, who has been more directly involved in insurance regulation than I may want to answer that.

My experience is that in the number of instances in States where there was a failure or a potential failure of a significant insurer, that even though the State government had no direct financial liability, the importance of that event to the citizens of the State almost invariably causes very significant involvement by the State government and very often constructive and positive involvement.

If one looks at some of the life insurance experience of the last several years or some of what has happened to some of our health insurers, I think the States already know how to protect consumers while protecting the State treasuries—I mean, instances in which insurers become insolvent.

Mr. Waxman. Thank you, Mr. McMillan.

Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

I just would like to clarify a couple things. In the health alliances, you are talking about insurance companies operating in the health alliances. I would imagine from what I have heard that there would probably be 4 or 5 larger insurance companies competing in each health alliance; is that correct?

Mr. VLADECK. I think they will be competing. In many alliances, I believe there will be other competitors as well.

Mr. HASTERT. So you see hundreds of people competing in each alliance.

Mr. VLADECK. I think that will depend on the size and characteristics of the market.

Mr. HASTERT. Aren't alliances really tied into the metropolitan statistical areas? That is what a alliance would be.

Mr. VLADECK. Yes. I believe that Albany-Troy-Schenectady is a metropolitan statistical area and so is New York City. I expect there are more competitors in the latter than the former.

Mr. HASTERT. How many competitors do you think there would be?

Mr. VLADECK. We have cities in the United States where there are 20 or 25 competitors. I don't remember the exact number, but when I get my Federal employees health benefits brochure as a Washington, D.C. employee, I have 20 or 25 choices.

Mr. HASTERT. The choices under the Clinton plan would be basically what the standard benefits package is, right?

Mr. VLADECK. No. I think the choices will primarily be made frankly on the basis of the individual component of the premium, the difference of the premium, and on the provider networks.

Mr. HASTERT. But the premium is paid by the 7.9 percent employer contribution.

Mr. VLADECK. The employer premium is fixed regardless of which plan the individual chooses. The individual premium is not. The individual, in effect, pays or the household pays the difference between the employer premium and the total——

Mr. HASTERT. Which is about 2 percent per employee.

Mr. VLADECK. I think it will vary, the individual——

Mr. HASTERT. How high could it be?

Mr. VLADECK. In the most expensive fee-for-service plans, it could probably be as high as four or five times as much as the household responsibility for the lowest cost plan.

Mr. HASTERT. I mean, you are talking about this in generalities. What is it?

Mr. VLADECK. If your average national premium per annum is $1,800 and the average individual will pay 20 percent of that or $360, I would expect in your big markets, the individual share of the premium for low-cost plans might be as low as zero and the individual share for the high cost plans might be as much as twice the average, that is to say, $720 a year, or $60 a month rather than $30 a month. There is no reason why that wouldn't happen.

Mr. HASTERT. And an individual in a company will have the opportunity to make that choice, right?

Mr. VLADECK. The individual within a regional alliance will have that choice. An individual within a corporate alliance may have a more restricted range of choice.

Mr. HASTERT. A corporate alliance applies to those working for a company with over 5,000 employees. I am talking about firms with less than 5,000 employees.

Mr. VLADECK. A small employer would have a choice across the spectrum.

Mr. HASTERT. OK. Now, you say the policies differ on price, not the benefits package. The benefits package then doesn't have any relationship to this or what?

Mr. VLADECK. Well, that is the whole point of guaranteeing the comprehensive benefits package, sir, to try to discourage competition on selection of which benefits are being covered within the basic framework so that every plan has to offer, as a minimum, the comprehensive package.

Mr. HASTERT. So, really, the choice then is what doctors are in what plans or what hospitals are in what plans?

Mr. VLADECK. I think that will be a large part of it, yes, sir.

Mr. HASTERT. Say it is a metropolitan statistical area, everybody has to have the same plan, don't they? Let's say Washington, D.C., for instance. Are you going to choose two hospitals?

Mr. VLADECK. Just as is now, for example, there are HMO's and preferred providers organizations——

Mr. HASTERT. Let's take Washington, D.C. Let me frame the question. Let's say two basic hospitals in Washington D.C., Sibley and another. What happens if the plan is filled up in Sibley?

Mr. VLADECK. Then——

Mr. HASTERT. Do you tell people where to go then?

Mr. VLADECK. As the——

Mr. HASTERT. Do you assign people to plans?

Mr. VLADECK. We assign people to plans only to the extent that there is no capacity in an area——

Mr. HASTERT. That is exactly what I said. When one plan is filled up, then you start to say, you can't go to that plan, you go to another plan; is that correct?

Mr. VLADECK. That is correct.

Mr. HASTERT. All right.

Mr. VLADECK. If you only have a very small number of plans.

Mr. HASTERT. It could happen, right?

So—that is a fast clock, Mr. Chairman. I think you have a D dial and an R dial. Someone told me you were the fastest clock in the west, I believe. I yield back my time.

Mr. WAXMAN. Well, you were in the middle of a sentence.

Mr. HASTERT. That is fine.

Mr. WAXMAN. Well, let's do a second round and I will do the same clock for everybody.

Mr. Vladeck, Mr. Cooper said to you that he didn't think the President campaigned when he was elected on this kind of health care plan. He presumed, I guess—I am sorry he is not here—that perhaps the President was suggesting to the country he was going to go with managed competition as written at the Jackson Hole conference by a group of people. As I recall the President's proposal

in the campaign, he said we want market forces, managed competition with budgeting.

That surprises those who want managed competition as per a certain version but also surprises me because now that we are seeing the President's proposal, he is letting the States run it. That was never mentioned. Not that he was bound by everything he mentioned in the campaign.

You testified the President's plan has built in disincentives for States which do not participate. These include reductions in the amounts that the Federal Government pays in a nonparticipating academic health centers and disproportionate share hospitals. In addition, the State will be charged a 15 percent premium surcharge, a large sum of money.

My question is why? Why do we want to coerce a State to participate that really didn't want to do so and how good could the resulting State program be? I could see that we might want to let States have a role in this, but if a State doesn't want it, why are we forcing it on them? And why couldn't we have a program that lives up to the President's campaign promise without the States being involved?

Mr. VLADECK. Well, Mr. Chairman, I don't know that I can answer your question directly, but I think it is very clear that the bias in this proposal throughout is to minimize the extent of additional Federal administrative responsibilities and the extent of increments in the Federal bureaucracies.

So, part of the answer as to why require the States to do it, even if they don't want to, is because if the States don't do it and you are going to have universal coverage, then the Federal Government has to do it. And we think there are some real advantages all around in having the States rather than the Federal Government do many of these things, the most important of which have to do with issues of ability to account for diversity and heterogeneity and the political closeness of State governments and State elected officials to the communities in which health care is delivered.

Mr. WAXMAN. As a technical matter, we could do all these things without State-run programs that the administration sets out to do and we could even vary the programs to meet various community concerns and differences as a technical matter; isn't that correct?

Mr. VLADECK. That is correct. The States are already engaged in the regulation of health insurance just for example. We are not at the Federal level. Rather than establishing a Federal bureaucracy to regulate health insurance, given the existence of the State structures and the very variable at the moment State capacities in that regard, it seems to us to make a lot more sense to strengthen the State's abilities to do this job rather than reinventing the wheel in Washington.

Mr. WAXMAN. But if a State says to the Federal Government, thanks a lot, but no thanks, we don't want to run this program, what will happen?

Mr. VLADECK. Well, then we will establish the program. Because our ultimate responsibility is to the public, to the citizens, not to the governments. We think the citizens are better served if their State governments undertake these functions. If they flat-out

refuse, we still have that obligation to see that the citizens get access to high quality health care.

Mr. WAXMAN. You have set pretty severe sanctions against States that don't want to run the program to force them to do it. In effect, you are holding a gun to their heads. If they are doing it reluctantly, shouldn't we have concerns as to whether they are going to do it begrudgingly and maybe inadequately because they really don't have their heart in it?

Mr. VLADECK. Mr. Chairman, I think——

Mr. WAXMAN. Some of these States don't like the Medicaid program and they were not enthusiastic about running that program at the State level.

Mr. VLADECK. I understand that. I think our experience with Medicaid suggests that we are better served, the beneficiaries are better served, and the public is better served if we don't spend too much time worrying about the States' motivation and focus our energies instead on their performance.

Mr. WAXMAN. That clock can't be right, but I guess it is.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Finally, on a couple of the previous questions. Let's assume and I think it is a reasonable expectation, that the District of Columbia would be an alliance. And let's assume that the private insurance companies with plans look around the region and decide that maybe they would like to insure the people in Virginia and elsewhere because Washington, D.C. has higher than average rates of gunshot wounds, AIDS and other high risk activities.

What happens if no one steps forward and says they would like to sell a plan to that alliance?

Mr. VLADECK. Again, if I may, I am just reluctant to continue to use D.C. as an example because it is so atypical, and I think it will require——

Mr. GREENWOOD. Let's use a hypothetical metropolitan statistical area that is at the high end of risk, the highest end of risk.

Mr. VLADECK. I think in the first instance, the alliance has a responsibility and an obligation to go out, as it were, and do two things. Actually, one is recruit insurers who otherwise might not want to enter the market.

Mr. GREENWOOD. Which you could only do through offering high premiums.

Mr. VLADECK. Or informing them, I think, that they don't have a lot of competitors in the market. The other thing that is going to happen, though, that is more critical is that the alliances and to some extent the States—and this will vary from State to State—will work with the provider community in those areas to develop their own plans.

And whether that is a single-payer plan or whether that is several competing plans, the key is that while there are metropolitan areas that have very different kinds of insurance markets, most metropolitan areas, as opposed to some rural areas, have in the aggregate enough providers around which to build plans. And, if an insurance company doesn't want to risk its capital, we have provisions to provide assistance in the States and alliances to let the

providers form their own networks. That is what I expect would happen in many parts of the country.

Mr. GREENWOOD. OK. The President's health care plan requires that States maintain their current level of spending on health care including their spending on Medicaid and portions of their public health programs. In particular, many States have been able to expand eligibility for Medicaid and offer Medicaid beneficiaries a rather generous benefits package.

I understand that the States will not have an opportunity to negotiate with the National Health Board on State specific maintenance of efforts which take into account these differences. Instead, a commission is charged with making recommendations by 1995 on how to reconcile these differences.

I would be interested in hearing your perspective on this approach to reconciling these differences: Is it fair to States and the beneficiaries to perpetuate these differences around the country? Do you have any alternatives to the proposed maintenance of effort which would take into account regional differences without punishing those States which have been generous in their programs while ensuring that beneficiaries continue to get the services they need?

Mr. VLADECK. Thank you, sir. I think you posed the question just right. I don't know what is fair. I don't know what the right answer is. This is one of the times I think when an administration proposes a commission not to arrive at a predetermined conclusion but because it recognizes that there is a very legitimate and very severe public policy problem out there and we don't know the best way to respond.

It was interesting hearing both Mr. Wyden and Mr. Kreidler talk about the concerns in their own States and Mr. Klug talking about Wisconsin's role. Everyone from every State thinks that their situation is unique and they are particularly deserving and particularly meritorious.

There are very significant sums of money involved. There are very fundamental issues of equity and of the structure of federalism involved. I think we can identify what many of these issues are. I think, ultimately, Mr. Madison and his colleagues tried to design the Congress to work out these sorts of issues, but we should see you get the best possible advice you can on this very hard problem and we don't know what the answer is.

Mr. GREENWOOD. Most States operate on a July to June fiscal year. Is there any evidence, that in anticipation of this provision of the plan, the States are scaling back those provisions of Medicaid that are not mandated.

Mr. VLADECK. If I am not mistaken, sir, the maintenance of effort formula looks at current level expenditures, so anything the States do after introduction of the bill would not affect the determination of their initial maintenance.

Mr. GREENWOOD. Thank you.

Mr. WYDEN [presiding]. A true 5-minute clock at this point.

Mr. GREENWOOD. A true chairman.

Mr. WYDEN. We have a true chairman and I think we all respect Chairman Waxman's interest in procedural protections.

Mr. Vladeck, let me ask you this, if I might again, about this matter of State accountability. I asked you about financial account-

ability earlier, but another kind of accountability stems from insurance regulation. And, obviously, again, you know the Governors are concerned that they don't have, in their view, the tools to try to drive people to the lower cost plans. It seems to me we ought to be looking at insurance regulations, specifically what the President's proposal calls for here.

Now, the General Accounting Office has been giving this committee and other committees report after report about State insurance regulation. GAO essentially says that the track record nationwide is spotty at best, and continually referred to extreme variability among the States. And I guess what I would be interested in is knowing what the President's bill will do to bring up the floor in terms of enforcement authority in the insurance regulation area nationwide.

Mr. VLADECK. Well, it does two things, I think. The first thing it does is establish a Federal framework for some of the characteristics of that insurance regulation activity in terms of some of the basic rules and basic expectations.

Our experience, by the way, with the implementation of those provisions in OBRA 90 that involve medigap insurance—which is the first experience I am familiar with of State insurance regulation within a Federal framework—suggests that merely having that framework is helpful. The results of implementation of that statute have been better, I think, than anyone ever expected.

The second thing, it again goes back to this initial process of the State being required to submit plans for implementation to the Board, and the Board presumably having some ability to set criteria for plan approval and in so doing to establish certain expectations about State performance. Clearly, in those States which have not had the tools or resources to do this job appropriately in the past, it is hard for me to envision how they would submit a plan that would be approved by the Board unless they took the steps necessary to significantly improve their capabilities.

Mr. WYDEN. Does the President's bill call for anything specific in terms of lifting the insurance regulation standards nationwide? I would have to differ with your characterization about medigap because I was intimately involved with that and that, in effect, put the fear of God in people that if it wasn't done at the State level, we were going to have the Federal initiatives kick in.

Is that the case here, because my understanding is that—and maybe I am not seeing something in the bill—that there is some general talky-talk about insurance, but we have gotten lots of that from the National Association of Insurance Commissioners over the years and yet we still get these General Accounting Office reports that there are a lot of States that have pretty spotty records.

Mr. VLADECK. Again, I think that is true. But, again, other than that very small OBRA 90 example, I am not familiar with any instance in which the Federal Government both set standards that the States had to implement relative to insurance and also set some requirements and expectations on the performance of State insurance regulation. So, the circumstances we are contemplating under this bill, I think, are not that under which we have been living the last number of years, and we have a high degree of confidence in the ability of States to deliver if they have to deliver.

Mr. WYDEN. I hope you will take a look at these GAO reports that have been spewing out over the last couple of years about insurance regulation because I do not have that degree of confidence, and it feeds directly into the very valid questions that a number of my colleagues on the other side of the aisle have talked about, what happens when we have these plans that are running into financial peril.

What happens, out of curiosity, when there is an insurance failure under managed competition in its purest form? We have been talking about what happens when there are insurance failures under the various other approaches, specifically the President's.

What happens when under pure Jackson Hole managed competition there is a failure?

Mr. VLADECK. If I am not mistaken, some of the variants of that theory would also presume the existence of guaranty mechanisms of some sort or another. Those are, again, very common in highly competitive insurance markets.

Mr. WYDEN. The gentleman from North Carolina.

Mr. MCMILLAN. Thank you, Mr. Chairman.

Mr. Vladeck, in the information provided yesterday, there is an item labeled new Federal administrative and startup costs. Admittedly we have got some of that. I think it totes over the 6-year period $9.6 billion, heavier in the first year and declining down.

I don't see any offsetting costs reductions in administrative costs, but I assume the assumption is that everything is so lean and mean that there are no potential savings in there.

But my main question focuses on the cost of running the original health care alliances. I don't see an approximation in there, and I assume that is a cost that is not going to be borne by Federal budget but by presumably the State budgets or some fee system within the alliances themselves, perhaps?

Mr. VLADECK. As I understand it, sir, the cost of operating the alliances will be incorporated into the premiums paid to the plans, which will in a sense pay a share of the premiums, which is capped in the bill at 2.5 percent, to the alliance's—to defray the alliance's operating expenses.

Mr. MCMILLAN. I don't know what that would be, but certainly one of the issues in terms of cost reduction is a reduction of administrative costs.

What is one is an adversarial claim system so on and so on. Hopefully, it will be simplified, but we are basically adding, are we not, an administrative layer and you can argue it is a constructive one, because it is going to foster competition which I would debate, but that is the assumption in the plan has been there is a cost of running that and it will be some factor of premium. I don't know what that is.

Mr. VLADECK. But what you are trading off, sir, for the cost of operating the alliance is the aggregation of the individual and small group market which has the highest proportion of administrative cost of anything in the health system.

So if the alliance has an operating cost up to the ceiling of 2.5 percent of premium volume, it is serving a set of functions that substitute for administrative costs in the range of 30 to 50 percent

as the overhead loadings on much of the small group health insurance market.

Mr. McMillan. You are talking about marketing costs as opposed to administrative costs.

Mr. Vladeck. Marketing, underwriting, costs associated with claims administration in the very small groups and small plans.

Mr. McMillan. I have never bought the argument that there was a percentage difference in the administrative costs of a large plan as opposed to a small plan by the underwriter. Now, there is a considerable difference in the marketing costs, which I would agree with.

One other thing I would want to pursue because I think we have had a little bit of a conflicting statement on this maybe earlier, we talked a little bit about the reliance of the plan upon premium setting by the National Board which will apply to virtually everybody out there in the system with the exception of Medicare beneficiaries.

Now, there are a number of proposed savings in Medicare as well as a number of proposed added benefits, the added benefits probably outweighing the savings, but savings fall generally, as I understand it, more in the revenue side than they do on the cost side. That means testing to some degree, the premium co-payments and things of that nature are most likely.

Is there anything in the plan that will put equivalent pressure on Medicare costs as exists on Medicaid and all the other subsidized costs in the alliances?

Mr. Vladeck. I am sorry, I am not in a position yet to give you the details, line by line, but about 80 percent of the Medicare savings we are proposing in the bill are savings in payments to providers, and only a very small part of the net savings involve increased outlays by beneficiaries.

Mr. McMillan. So you are then going in that area to attempt to define standard benefit levels somewhat comparable as will be necessary in all the other benefit packages?

Mr. Vladeck. I am not sure I follow your question, sir.

Mr. McMillan. Well, you have got to—I think the problem with Medicare today, the reason it is out of control is we don't define precisely what it is we are going to reimburse. And do you propose in your reform proposal to do that?

Mr. Vladeck. Well, I would differ with your assumption there, sir. I would argue that Medicare has significantly more precise definitions on what it is going to reimburse than just about anyone else. I think our major problems with Medicare costs are that we pay too much for some services and, more importantly, we buy far too many of other services. But it is not because we can't define what we are paying for, it is we can't define that we really need what we are paying for and when we are paying for substantially more marginal benefits.

Mr. McMillan. I look forward to seeing that because, as you well know, we are faced with a 12 percent compound rate of growth in contrast to the very different assumptions in health care reform, so I would look forward to that.

When will that detail be——

Mr. VLADECK. I understand I will have the pleasure of discussing that with you in this room several weeks from now.

Mr. MCMILLAN. Very good. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

The State obviously can establish one or more health alliances within that State. My understanding is geographic boundaries of the alliances may not divide SMSA's, may not cross State boundaries. Much of this plan seems to give as much flexibility as possible to States to health alliances kind of all across the Board. I think people later talking, people testifying later from NGA and the counties and all are going to urge that we inject, if you will, more flexibility into this whole plan.

Talk to me a little bit about your rationale in making decisions on the health—allowing the boundaries of health alliances not crossing State lines, not cutting across SMSA's, not dividing them up. Talk to me a little about that rationale, if you would.

Mr. VLADECK. Frankly, I can't answer the question on not crossing State lines other than saying that in the past when the Federal Government has tried to encourage the creation of multistate entities, we don't forbid it, we just don't require it. And it gets to be very complicated, and if it is something the States want to do, more power to them and they ought to do it, but we oughtn't try to encourage or discourage it or we will just make a mess.

In terms of the very limited discretion on alliance boundary definition within the State, there are some fundamental criteria that the Federal Government insists on in this proposal. The first criterion is that the alliance areas be large enough to make economic sense. That is to say that the basic purpose of an alliance, which is to create a purchasing pool large enough to give market power to the consumer, be carried out.

The other is to address as strongly as we can our major concern about the definition of plan and alliance boundaries to minimize the risks of discrimination on any of a number of grounds that have been so pervasive in the insurance business.

And, therefore, the requirements about metropolitan areas in particular as well as the other language of that section of the proposal are targeted almost entirely at trying to minimize the risk of red lining or gerrymandering.

Mr. BROWN. If I could, aren't States—do we need to write that into this? Aren't States going—States aren't going to desegregate a poor area of town and a wealthy area into one alliance and a wealthy suburb in another alliance and much smaller kinds of alliance, are they? Do we need to tell them to do that?

Mr. VLADECK. Well, I would suggest that our experience in public education, for example, does not permit us to have total confidence in the States on that regard.

Mr. BROWN. Fair enough. What would you say is one of the things about—one of the things disturbing overall to me about this whole plan is the complexity and difficulty of explaining it to people. And with people's incredible confidence in government nowadays, particularly when they don't much understand this plan, it makes it so much more difficult for all of us, I think. People espe-

cially don't understand sort of the concept of health alliances, the size of them, all that.

What would you say—if this is a fair question, or even if it isn't, I will ask it anyway—what would you say is sort of the smallest alliance in population that you can see forming by the States in population for the geography?

Mr. VLADECK. In population——

Mr. BROWN. Sort of actuarially sound, kind of, to spread the risks.

Mr. VLADECK. I don't know if we have even talked about that hypothetically. I would think from the viewpoint of the administrative burden, if one thinks about the States and where people live, thinks about the least populous States as being single alliance areas, I think one is talking about a population of several hundred thousand people.

When you got into larger States, in Ohio or New York or even Maryland, if you had alliance populations much smaller than that, the proliferation of alliances itself would get to be a problem.

So, on the other hand, the Wyoming or Alaska alliance is probably large enough from an actuarial point of view. I think somewhere on the order of several hundred thousand people on a minimum. I think, on a norm, it would be more like a million or something larger that.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you Mr. Brown.

Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

Mr. Vladeck, I want to go back to one statement you made when my time expired. You said that people could be moved out of a plan if it reached capacity and you said, using the example of the District of Columbia, that would only happen if there was just a shortage and not many plans were offered in the system.

Wouldn't it also be true if there was 1 plan, out of 10 plans offered in a system, that was most desirable and it reached capacity, then the government would direct people into plans that they chose not to be in. Is that correct?

Mr. VLADECK. First of all, you would be directing them into their second choice plan. And second, you would be assuming——

Mr. HASTERT. The point is, you are redirecting them out of their first choice and saying you can't have that plan. You make that decision.

Mr. VLADECK. Just exactly the same way that not everyone who wants tickets to the most popular ball game in town is going——

Mr. HASTERT. A popular ball game doesn't mean whether you get an operation tomorrow or the doctor of your choice or anything else. There is a little difference.

Let me ask you another question. Not only can you not cross State lines, but you really can't cross metropolitan statistical areas either, can you? Those are defined in the law.

Mr. VLADECK. The whole area has to be in an alliance, but you can have an alliance that includes an MSA and other areas or, in fact, an alliance includes multiple MSA's as long as it doesn't subdivide the MSA's within it.

Mr. HASTERT. Let's say the MSA that I happen to be in has multi-millions of people. Do you have to have multi-millions of people to avoid red lining?

Mr. VLADECK. I don't think you need multi-millions of people for actuarial——

Mr. HASTERT. I am just saying that the metropolitan statistical area that I am in has multi-millions of people. We have no choice. We have to be in that area. You can't subdivide the MSA.

Mr. VLADECK. That is correct, but——

Mr. HASTERT. Now, the point is, the design is that employers pay into that insurance program and subsidize areas where people don't work. That is the design, right, it is a cross-subsidization?

Mr. VLADECK. That is correct.

Mr. HASTERT. Fine. Would you say that is correct? I mean, the system is to cross-subsidize.

Mr. VLADECK. I misspoke. The discounts for nonworkers or part-time workers come from Federal financing, not from the premiums paid by workers or their employers.

Mr. HASTERT. What happens to the excess premiums?

Mr. VLADECK. What excess premiums?

Mr. HASTERT. Excess premiums. Say there are two workers in a family.

Mr. VLADECK. In the aggregate, the premiums are set to cover the costs of the services.

Mr. HASTERT. In the aggregate of the MSA?

Mr. VLADECK. Actuarially, it should work in the aggregate at the level of an employer.

Mr. HASTERT. But it doesn't work in the aggregate of the MSA.

Mr. VLADECK. It works in any reasonable aggregate.

Mr. HASTERT. Right. So you do have a cross-subsidization there. I think you spoke correctly the first time.

Mr. VLADECK. No, I didn't. I did misspeak. The only cross-subsidization, which is very modest, is between different family types.

Mr. HASTERT. Different family types?

Mr. VLADECK. That is correct, because of depending on within an individual employer——

Mr. HASTERT. Isn't everybody a family type?

Mr. VLADECK. Some people are single parents, some people are two-parent households.

Mr. HASTERT. And some people are just single. That is a family type, so that almost is a whole population of people.

Other point, you were talking about the uniqueness of every State having its own problems. One of the things that the State of Illinois has tried to do, because we have some unique problems, they have gone out and put basically a user tax, a grandma's tax on people who use health care services.

That won't be available—you can't do that anymore under this new scenario. So, are you saying that the States then have to find new revenue sources to pick up the cost of Medicaid?

Mr. VLADECK. I don't think there is any limitation on the States' taxing authority contained in this proposal.

Mr. HASTERT. Even on health care services?

Mr. VLADECK. If I am not mistaken, we do not limit——

Mr. HASTERT. It would be a good clarification, because when a State starts to tax health care services, you raise the cost of the health care. And, you know, it throws your whole scenario out of whack. I would think of trying to hold down costs. My question is, when you start to purge out $90 billion out of DSH money in Medicaid over the next 5 years, I think that is the program, you redirect those funds, how does the State start to make up that deficit?

Mr. VLADECK. Well to the extent the State is using DSH payment as the law intends to pay providers who are caring for uninsured persons, the extension of universal coverage will substitute for those payments. To the extent the State is paying itself with Federal funds through the use of DSH-related mechanisms, they will in fact have to find other mechanisms.

Mr. HASTERT. Thank you.

Mr. WAXMAN. Thank you, Mr. Hastert.

Mr. Synar.

Mr. SYNAR. Thank you, Mr. Chairman.

Welcome. I really only have one question. By the year 2000, we estimate another 15 percent of the rural hospitals in the United States will close. A lot of that will be because they just can't deliver the basic quality of care that they are going to get.

This plan gives a lot of flexibility to States to look over geographic bounds and try to provide the same service for urban and rural areas.

Last week this committee, under another subcommittee headed by Mr. Markey, created a grant program for telemedicine to have a clearinghouse through the Department of Commerce so that the information that we gather can then get down to the rural areas. Whether or not that even works will depend a lot on whether we can have reimbursement and the liability problems solved, and most importantly, whether or not we can have some cost sharing.

Is the administration prepared to sit down and try to work those types of things through so that telemedicine can help bridge the gap between urban and rural areas?

Mr. VLADECK. Sir, as you may have heard, I met a couple of weeks ago with a group of your colleagues in both the House and the Senate from rural areas on the subject of telemedicine, and we promised them a statement of an administration position on Medicare reimbursement and related issues for telemedicine in trying to incorporate them into legislative proposals for the next session of this Congress. We are on track to do that. I can't give you the answer now, but by Christmas we will have a set of very specific proposals.

Mr. SYNAR. But those issues of reimbursement and liability and cost sharing are part of that?

Mr. VLADECK. Yes, sir. Absolutely.

Mr. SYNAR. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you Mr. Synar.

Mr. Vladeck, we appreciate your being here with us today. Members may have additional questions on this subject we would like you to respond to in writing.

Mr. VLADECK. I would be happy to do so.

Mr. WAXMAN. I didn't realize this was your first appearance before us as the head of HCFA. You have been a witness over the

years and done an excellent job. I want to commend you for doing an excellent job today as well.

Mr. VLADECK. Thank you very much. I will be back.

Mr. WAXMAN. We are going to have you back often.

Our first panel consists of representatives of the States and counties. Mr. Ray Scheppach is Executive Director of the National Governors Association; The Honorable Charlene Rydell is a member of the House of Representatives of the State of Maine and is testifying today on behalf of the National Conference of State Legislatures; the Honorable Barbara Shipnuck is the chairwoman of the Monterey County, California Board of Supervisors. She is testifying on behalf of the National Association of Counties.

We want to welcome you to our hearing today. Your prepared statements will be included in the record in their entirety. We would like to ask you, if you would, to please limit the oral presentation to no more than 5 minutes.

Mr. Scheppach, why don't we start with you. That button on the base of the mike, be sure to push it forward.

STATEMENTS OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION; CHARLENE RYDELL, ON BEHALF OF NATIONAL CONFERENCE OF STATE LEGISLATURES; AND BARBARA SHIPNUCK, ON BEHALF OF NATIONAL ASSOCIATION OF COUNTIES

Mr. SCHEPPACH. Good morning, Mr. Chairman and members of the subcommittee. I appreciate the opportunity to appear before you today on behalf the Nation's Governors to discuss the role of States in health care reform.

In this statement, I would just like to summarize two quick issues: One, what is the appropriate role of States in health care reform, and second, what is the Governors' reaction to the President's Health Care Security Act.

Let me be very clear, Mr. Chairman. The Governors do not want to have 50 different State programs. Governors want portability of health care benefits from State to State and they are extremely sensitive to the concerns of multi-corporations and multi-city State employers.

It is for these reasons that the NGA supports a very strong Federal framework that includes, first, the enactment of the Federal legislation to eliminate medical underwriting and to establish community rating. Second, one national benefit package that is required in all States.

Third, Federal malpractice guidelines that States will follow. Fourth changes in Federal antitrust legislation. And fifth, medical outcome and quality information standards.

Not only are these elements of a strong Federal framework but they represent a considerable amount of preemption of State authority in a number of areas. Nevertheless, the Governors feel they are necessary to develop an efficient delivery item for health care.

The other major component necessary to develop an efficient system is State flexibility. States need that flexibility to administer the program on a day-by-day basis within this Federal framework. Essentially, this means flexibility in designing, regulating, and overseeing regional alliances and accountable health plans. The fol-

lowing are some of the advantages we see of the State based system.

First, States are large enough to gain the economies of scale and yet small enough to tailor their systems to the unique needs and cultures of the individual States.

Second, since this is a new system that will require us to move into very uncharted waters, therefore it is critical to offer State innovation and experimentation to design the most efficient system, this will also allow for mid-course corrections and adjustments without the requirement of a Federal waiver or changes in Federal legislation.

Third, given that the implementation of a new system will take 3 to 5 years, it is critical that a sustained commitment in support of health care reform be maintained at the grassroots level. Allowing State flexibility to accommodate and adjust to local concerns will help maintain that commitment.

Finally, States already have significant expertise in administering health care programs such as Medicaid, State employees' health, as well as insurance regulation. It is important to build on this expertise.

I would like to note, however, that while there is significant agreement among Governors on the State role in national health care, they do not agree on all aspects of the President's plan. Most notable among these issues is the President's strategy to finance the new system.

With respect to the Governors' reaction to the Clinton Health Security Act, the Governors support the State-Federal partnership that is incorporated into the President's plan. It provides the strong Federal structure that is essential for true reform, yet there is ample flexibility so that States can develop and implement delivery systems that will work in both urban and rural settings and under diverse socioeconomic conditions.

With respect to the first issue on alliances and accountability health plans, the Governors support the flexibility in that they can determine both the number of alliances and the regional boundaries. Second, the flexibility they have under Federal guidelines of appointing board members and also having the flexibility to design the legal entity, be it a quasi-government agency or a nonprofit.

They are, however, concerned about the limitation and not being able to divide SMSA's. While they agree with the intent of legislation with respect to not allowing for discrimination and would agree to stronger language in that regard, they are concerned that in some States it may be important to divide SMSA's so you can incorporate a rural area with a portion of the SMSA to increase the quality in coverage to that rural area. If you are not willing to give that flexibility, at least a waiver as part of a plan would be appreciated in that regard.

The Governors also support the flexibility for a single-payer system. My sense is that there will not be very many States that choose that option. It will probably be seriously considered in a handful of States. My sense is four to five States. I am not sure whether any will choose it, but I think it is an important option, particularly since we are going into uncharted waters.

The Governors also support the State oversight over the accountable health plans and particularly allowing States to choose where the rate regulation on fee-for-service groups will be, where that jurisdiction lies within the State itself, or they can vest that responsibility essentially in the alliances.

Mr. WAXMAN. Thank you very much Mr. Scheppach, the rest of the statement is going to be in the record.

Mr. SCHEPPACH. Thank you.

[The prepared statement of Mr. Scheppach follows:]

STATEMENT OF RAYMOND C. SCHEPPACH

Good morning Mr. Chairman and members of the subcommittee. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the role of states in health care reform.

In this statement I would like to summarize three major issues.

- The Governors' health care reform policy;
- The appropriate state role in health care reform; and,
- The Governors' reaction to President Clinton's Health Security Act.

THE GOVERNORS' HEALTH CARE REFORM POLICY

Last February, the Governors adopted a comprehensive policy on national health reform that calls for universal access to quality and affordable health care. The policy supports a national health care system that recognizes the importance of federal uniformity in health reform but at the same time recognizes the essential roles and responsibilities of states in the administration and delivery of health care. The Governors support a framework that includes managed competition; a national benefits package that includes primary and preventive care; guaranteed issue and portability of coverage to end the discriminatory insurance practices that are used to deny coverage; tort reform; antitrust changes; administrative simplifications; and the development of national health outcomes so that Americans can assess the efficacy of their health care. The policy also calls for purchasing cooperatives at the state level.

The Governors believe that strong cost control systems are integral to any health care reform system adopted for the nation. The Governors chose not to endorse enforceable budgets from the outset, preferring budget targets in the early years. They reasoned that setting enforceable budgets for one-seventh of the American economy requires a stable and objective national data system. Such a system does not now exist. Thus, the premature setting of budgets could have

some unintended negative effects. And while it is not the subject of this hearing, the Governors call for major reform of the Medicaid program so all current Medicaid recipients would receive their acute care coverage through purchasing alliances.

THE APPROPRIATE STATE ROLE IN HEALTH CARE REFORM

Let me be clear, Mr. Chairman, that Governors do not want to have fifty different state programs. Governors want portability of health care benefits from state to state and are extremely sensitive to the concerns of large multistate employers. It is for these reasons that the NGA supports a strong federal framework that includes:

1. The enactment of federal legislation to eliminate medical underwriting and establish community rating.
2. One national benefit package that is required in all states.
3. Federal malpractice guidelines that states will follow.
4. Changes in federal antitrust legislation.
5. Medical outcome and quality information standards.

Not only are these elements of a strong federal framework, but they preempt state authority in a number of important areas. Nevertheless, they are necessary to develop an efficient delivery system for health care. The other major component necessary to develop an efficient system is state flexibility. States need to have the flexibility to administer the program on a day-to-day basis within this federal framework. Essentially, this means flexibility in designing, regulating, and overseeing the regional alliances and accountable health plans. The following are the advantages of a state-based system.

- States are large enough to gain the economies of scale and yet small enough to tailor the system to the unique needs and culture of the individual states.

- Since the new system will require us to move into uncharted waters it is critical to allow for state innovation and experimentation to design the most efficient systems. This also allows for mid-course corrections and adjustments without the requirement of a federal waiver or changes in federal legislation.
- Given that the implementation of a new health care system will take three to five years it is critical that a sustained commitment in support health care reform be maintained at the grass root level. Allowing state flexibility to accommodate and adjust to local concerns will help maintain that commitment.
- States already have significant experience in administering health care programs, such as Medicaid and state employees' health care, as well as insurance regulation and other regulation of providers. It is important to build on this expertise.

I would like to note, however, that while there is significant agreement among the Governors on the state role in national health reform, they do not agree on all aspects of the President's plan. Most notable among these issues is the President's strategy to finance the new system.

THE GOVERNORS REACTION TO PRESIDENT CLINTON'S HEALTH SECURITY ACT

Mr. Chairman and members of the subcommittee, the Governors support the state/federal partnership that is incorporated into President Clinton's plan. It provides the strong federal structure that is essential for true reform, yet there is ample flexibility so that states can develop and implement a delivery system that will work in both urban and rural settings and under diverse socioeconomic conditions.

Alliances and Accountable Health Plans -- The Health Security Act gives states discretion on the number and regional boundaries of alliances. This will enable individual states to consider how its provider community and local governments are organized. The Governors support such

latitude but still have some questions about one aspect of this provision. The act does not permit metropolitan statistical areas to be divided into different alliances. As we understand it, the policy was designed to preclude discriminatory practices in drawing alliance boundaries. We support the antidiscriminatory language in the act and, if necessary, would support stronger language to give states the broader flexibility at issue. However, at the very least, there should be a waiver provision to allow the division of metropolitan statistical areas. Our concern is that it may be important in some states to draw boundaries that include rural areas with a part of the SMSA. This may increase the quality of care that is available in rural areas. Finally, the Governors support the flexibility to decide the legal entity governing the alliance (i.e., state agency, quasi-governmental agency, or private nonprofit organization).

The Governors support the flexibility of the single-payer option described in the act with one modification. The act requires the single-payer system to be operated by the state or a designated agency of the state. The Governors prefer to be able to contract out all or parts of a state's operation to the private sector and would like the legislative language to specifically allow this option.

The Governors also support the authority vested in states to certify accountable health plans (AHPs) as well as to oversee the audits and guarantee funds. Although every state has had experience in provider enrollment and certification as part of Medicaid, not all states have had extensive experience with larger plans. We believe that cooperation among states and between states and the federal government during the transition to the new system will enable states to perform this function. It is critical that states have authority over both the alliances and the AHPs.

While giving states flexibility in the establishment and administration of health alliances and AHPs, the legislative text confuses lines of authority between the federal and state governments by giving

both the federal government and states some direct oversight and regulatory control over these entities. This could dilute accountability and may hurt the administrative efficiency of the system. Although the federal government has a legitimate interest in the efficient and effective operation of alliances and AHPs, the interest is best expressed through direct oversight of state governments, which can then regulate and oversee alliances and plans. We suggest that the federal government provide appropriate general guidelines rather than direct oversight.

While Governors may differ on the need for setting fee-for-service rates they appreciate the ability for states to set rates for the entire state or to have them vest this authority in regional alliances, as appropriate.

Finally, there is some concern about the responsibility of states to ensure adequate access to a choice of health plans, as described in the act. The language calls not only for choice, but also for access to plans at or below the weighted average premium "to the maximum extent practicable." The availability of plans will, to some extent, be determined by the premium budget assigned to the alliance and the number of AHPs that choose to bid within that budget cap. Because states will have no control over the budget that will be set nationally, states will not have the tools to ensure choice. Moreover, the act stipulates a right to enforce state responsibilities through 42 U.S.C. 1983 that is quite onerous. We suggest that the state responsibility for access language be deleted from the legislation.

Premium Caps -- As I said earlier Mr. Chairman, the Governors' policy supports budget targets in the early years of national reform rather than immediate enforceable premium (budget) caps as detailed in the Health Security Act. Although the cap is determined and enforced by the federal government, the impact on states may be direct. If the federal government fails to set reasonable limits in the first several years, states will be left with the responsibility for correcting the damage done to providers, networks, and the availability of health care. The Governors urge caution in

setting premium caps in the early years of health reform. While urging caution, the Governors do support the provision in the act that gives financial incentives to states to try to bring the alliances in under budget. Without this incentive, one can expect that each alliance would negotiate premiums that are equal to the premium cap set by the National Health Board.

Transition to the New System -- States may begin implementing the new system as early as January 1, 1996, with all states participating within two years. Although this deadline is somewhat ambitious, Governors believe that it can be met with the additional planning and start-up funds detailed in the legislative text. In fact, some states would prefer to begin operating a national system before the 1996 start date.

Currently, a number of states are establishing voluntary alliances, and others will be considering such legislation next year. These states will serve as laboratories for the President's approach, and other states will be able to benefit from their experiences. Essentially, the two-year window will allow states such as Florida, Hawaii, Minnesota, Oregon, Vermont, and Washington to implement early, since many of them already have enacted major health care reform. Similarly, it will give other states more time to implement. It is important to have the planning and start-up funds in the proposed legislation. States will have strong incentive to implement early since they will receive low-income and small business subsidies when they trigger on the new system.

New Community-Based Long-Term Care Program -- The act creates a new community-based long-term care program for persons with significant functional impairments. The Governors support community-based alternatives to institutional care, and the act has several provisions, including this one, consistent with that position. And, while the Governors support community-based long-term care, the financing of this new program raises some concerns. Specifically, federal participation, though significant, is limited, while the state financial exposure may not be. In general, we believe that issues related to community and institutional long-term care need

greater consideration by Congress either as a part of national reform or separately in the near future.

CONCLUSION

Mr. Chairman and members of the subcommittee, as you well know, the legislative text of the President's plan is more than 1,300 pages in length. The testimony given before you today is based on our first review of the plan. The devil, however, is always in the details and we continue to examine the language. Over the next several weeks, as additional issues arise, we will be sure to keep you informed.

Finally, after too many years, the nation appears ready for meaningful national health reform. The nation's Governors support reform that provides universal access to quality and affordable health care. Moreover, the Governors strongly believe that states must have an integral role in any reform strategy. The Governors look forward to working with each of you as you begin to craft the final legislative package. Working with its sister organization, the National Association of State Budget Officers, the National Governors' Association is gathering information on the state fiscal impact of the Health Security Act. As summary data becomes available, we will make that information available to you for your deliberations.

Thank you for the opportunity to appear before the subcommittee today. If you have questions, I will be glad to answer them.

Mr. WAXMAN. Ms. Rydell.

STATEMENT OF CHARLENE RYDELL

Ms. RYDELL. Thank you, Mr. Chairman. My name is Charlene Rydell, and I am a member of the Maine House of Representatives, and today I am speaking on behalf of the National Conference of State Legislatures, NCSL.

Our goal is to help craft a plan that provides for, one, health care coverage for all residents of the United States; two, Federal guidance with a strong, meaningful role for States in program design and implementation; three, equity for and between States; and four, a strong fiscal base.

We feel the only way to provide full access and to control health care costs is to establish a program where everyone is covered. While we agree that some national uniformity is desirable, we will actively oppose Federal preemption unless preemption is the only reasonable means of reaching a compelling national objective.

However, the appropriate role of the Federal Government is to set national standards, and to establish goals. Each State should determine the best way to meet the goals and to implement the national standards. It is important to pay special attention to the State-by-State and regional impact of health care reform proposals.

I would like to outline some of our areas of concern with the President's plan. We were extremely pleased that States would be officially represented on the National Health Board but we still have concerns about the degree of power vested in the Board. The National Health Board would establish and enforce budget targets. We feel that States must have a role in developing those targets and that States, not the National Health Board, should enforce them and be permitted to utilize the full range of strategies to control costs while maintaining quality and guaranteeing access. If States are to be accountable, they must have the necessary tools.

The proposal gives States the primarily regulatory authority over the regional health alliances. We believe this is appropriate. The Federal Government should develop broad guidelines and let States determine the structure, function, and governance of health alliances.

NCSL believes that participation in the regional alliances should be as inclusive as possible. We see no strong public policy interests for the establishment of corporate alliances. In States like Maine, for example, if all the large employers were to choose to put their employees into separate corporate alliances, the remaining individuals may not represent the population large enough to provide the regional alliance with adequate negotiating strength in some geographical areas.

We are also concerned that firms will initially establish corporate alliances and then for financial reasons or expediency, decide to put their employees in regional alliances. We would have concerns about economic downturns or layoffs or, in the cases that I am most familiar with, seasonal labor force reductions. The local impact of such changes have both budget and service delivery implications.

We feel it would be simpler and more efficient to put everyone in the alliances and to allow States to opt entities out provided they could do so and meet the requirements of the law.

We urge the administration to permit more flexibility regarding designation of alliance boundary lines. States like Maine may be able to establish more efficient delivery service systems, more strongly-linked risk pools, if the alliances were permitted to cross State lines. The Clinton proposal would preempt a broad range of State laws. We believe all Federal preemption should be carefully scrutinized.

NCSL supports the establishment of several standard benefit packages and that would include insurance guidelines and operating standards, but believes States should continue to regulate insurance, including supplemental coverage.

With respect to essential community providers, the primary responsibility for identifying and designating these providers should be a State responsibility in collaboration with local government.

NCSL policy calls for the inclusion of community health centers, school clinics, public health clinics, and other providers in the network of providers eligible to provide services. The exact designation of essential providers may vary among States.

As State legislators, we have extensive experience with the Medicaid program. The program does not provide a firm foundation for a new system. True equity in our health care system requires we decouple health care services from eligibility from cash assistance programs.

If the comprehensive standard benefit package fails to provide adequate coverage for certain individuals, adults or children, the eligibility for the supplemental program should be standard and the financing should be clearly set out. If the individuals are to be entitled to these benefits, the program cannot be capped.

The administration has proposed a new program to provide additional residual Medicaid coverage to certain children in low-income households. The new program for children and this approach, in general, violates one of the administration's six principles for health care reform, simplicity. The new children's program has three separate eligibility categories for children up to age 18. Moreover, the program is funded as a capped entitlement.

With respect to long-term care, NCSL is studying the provision of the law that would permit States to integrate all State long-term care programs into one. We are concerned that individuals would no longer be entitled to long-term care services. Since the program is capped, that would probably be a necessary condition.

With respect to undocumented individuals, we feel the Federal Government should address this problem squarely. As States, we cannot deny health care to those individuals should they appear at the hospital or clinic but we should not be left inadequately assisted, and it may affect some States very, very disproportionately in this particular proposal.

With respect to taxes, the effect on State taxes, the President's plan affects the State taxes. For example, the premium tax and insurance has long been a traditional State revenue source that we believe should not be compromised.

In conclusion, with respect to transition, Mr. Chairman, we further believe that as the Federal Government debates the details of health care reform, States should be afforded maximum flexibility to continue or to begin innovative reform of their health care delivery systems before the Federal system is in place.

We support the establishment and implementation of an expedited waiver process by which States can receive multiyear waivers of requirements under Medicaid, Medicare, ERISA, and other Federal laws. ERISA in dollars presents a stumbling block to State efforts to design universal affordable care.

Our goal is to be active participants in developing a comprehensive reform strategy based on the principles of universal coverage and a strong role for States in program design and implementation under Federal standards and Federal guidance. We believe there should be equity between States and a firm fiscal foundation.

I appreciate this opportunity to share our initial views regarding President Clinton's health care reform proposal and look forward to working with you over the coming months. Thank you.

Mr. WAXMAN. Thank you very much, Ms. Rydell.

[Testimony resumes on p. 72.]

[The prepared statement of Ms. Rydell follows:]

STATEMENT OF CHARLENE RYDELL

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

MY NAME IS CHARLENE RYDELL. I AM A MEMBER OF THE MAINE HOUSE OF REPRESENTATIVES AND TODAY I AM SPEAKING ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL)[1] WHERE I SERVE AS VICE CHAIR OF THE STATE-FEDERAL ASSEMBLY (SFA), THE POLICYMAKING BODY THAT GUIDES OUR ADVOCACY ACTIVITIES WITH CONGRESS, THE COURTS AND THE FEDERAL ADMINISTRATION.

MY TESTIMONY TODAY IS BASED ON NCSL POLICY WHICH REFLECTS OUR DEDICATION TO PRESERVING A STRONG FEDERAL SYSTEM OF GOVERNMENT, PROTECTING OUR NATION'S VULNERABLE POPULATIONS, DEVELOPING CREATIVE, CONSTRUCTIVE DOMESTIC INITIATIVES, AND FORGING AN EFFECTIVE STATE-FEDERAL HEALTHCARE REFORM PARTNERSHIP.

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE STATE ROLE IN PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL. NCSL HAS ENDORSED NO SPECIFIC PLAN OR APPROACH. OUR GOAL IS TO HELP CRAFT A PLAN THAT PROVIDES FOR: (1) HEALTH CARE COVERAGE FOR ALL RESIDENTS OF THE UNITED STATES; (2) FEDERAL GUIDANCE WITH A STRONG, MEANINGFUL ROLE FOR STATES IN PROGRAM DESIGN AND IMPLEMENTATION; (3) EQUITY FOR AND BETWEEN STATES; AND (4) A STRONG FISCAL BASE.

THE ONLY WAY TO PROVIDE FULL ACCESS AND TO CONTROL HEALTH CARE COSTS IS TO ESTABLISH A PROGRAM WHERE EVERYONE IS COVERED. WHILE WE AGREE THAT SOME NATIONAL UNIFORMITY IS DESIRABLE, WE WILL ACTIVELY OPPOSE FEDERAL PREEMPTION UNLESS PREEMPTION IS THE ONLY REASONABLE MEANS OF REACHING A COMPELLING NATIONAL OBJECTIVE. THE APPROPRIATE ROLE OF THE FEDERAL GOVERNMENT IS TO SET

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1 NCSL REPRESENTS THE LEGISLATURES OF THE FIFTY STATES, ITS COMMONWEALTHS, TERRITORIES AND THE DISTRICT OF COLUMBIA.

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NATIONAL STANDARDS, AND TO ESTABLISH GOALS. EACH STATE SHOULD DETERMINE THE BEST WAY TO MEET THE GOALS AND TO IMPLEMENT THE NATIONAL STANDARDS. IT IS IMPORTANT TO PAY SPECIAL ATTENTION TO THE STATE-BY-STATE AND REGIONAL IMPACT OF HEALTH CARE REFORM PROPOSALS. MOREOVER, A FIRM FINANCIAL FOUNDATION IS CRITICAL TO THE ESTABLISHMENT AND FULL IMPLEMENTATION OF COMPREHENSIVE HEALTH CARE REFORM. ELIGIBILITY AND/OR COVERAGE MAY NEED TO BE PHASED-IN OVER TIME.

NCSL APPLAUDS THE LEADERSHIP THAT PRESIDENT CLINTON HAS PROVIDED IN CALLING FOR HEALTH CARE REFORM AND HIS EFFORTS TO GUARANTEE LIFELONG HEALTH CARE COVERAGE. THE SIX BASIC PRINCIPLES OF THE PRESIDENT'S PLAN; SECURITY, SIMPLICITY, SAVINGS, QUALITY, CHOICE, AND RESPONSIBILITY, ARE CONSISTENT WITH NCSL'S POLICY. I WOULD NOW LIKE TO OUTLINE OUR AREAS OF CONCERN WITH THE PRESIDENT'S PLAN.

NATIONAL HEALTH BOARD

WE ARE EXTREMELY PLEASED THAT STATES WOULD BE OFFICIALLY REPRESENTED ON THE NATIONAL HEALTH BOARD (NHB). NCSL IS NOT HOWEVER, COMFORTABLE WITH THE PROPOSED ROLES AND RESPONSIBILITIES OF THE BOARD. THE ADMINISTRATION HAS MADE SOME ADJUSTMENTS IN THE ROLES AND RESPONSIBILITIES OF THE BOARD THAT GIVES MORE AUTHORITY TO STATE GOVERNMENTS. WE BELIEVE THIS IS MOVEMENT IN THE RIGHT DIRECTION, BUT STILL HAVE CONCERNS ABOUT THE DEGREE OF POWER VESTED IN THE BOARD.

THE NHB WOULD ESTABLISH AND ENFORCE BUDGET TARGETS. NCSL HAS TAKEN NO POSITION ON WHETHER BUDGET TARGETS SHOULD BE ESTABLISHED, BUT BELIEVES THAT, IF TARGETS ARE ESTABLISHED, STATES MUST HAVE A ROLE IN DEVELOPING THEM AND STATES, NOT THE NHB, SHOULD ENFORCE THEM AND SHOULD BE PERMITTED TO UTILIZE THE FULL

RANGE OF STRATEGIES AVAILABLE TO CONTROL COST WHILE MAINTAINING QUALITY AND IMPROVING ACCESS.

REGIONAL AND CORPORATE HEALTH ALLIANCES

THE PROPOSAL GIVES STATES THE PRIMARY REGULATORY AUTHORITY OVER THE REGIONAL HEALTH ALLIANCES. WE BELIEVE THIS IS APPROPRIATE. THE FEDERAL GOVERNMENT SHOULD DEVELOP BROAD GUIDELINES AND LET STATES DETERMINE THE STRUCTURE, FUNCTION AND GOVERNANCE OF THE HEALTH ALLIANCES.

NCSL BELIEVES THAT PARTICIPATION IN THE REGIONAL HEALTH ALLIANCES SHOULD BE AS INCLUSIVE AS POSSIBLE. WE SEE NO STRONG PUBLIC POLICY BASIS FOR THE ESTABLISHMENT OF CORPORATE ALLIANCES. THE LAW WOULD REQUIRE STATES TO: ".. ENSURE THAT EACH ALLIANCE ENCOMPASSES A POPULATION LARGE ENOUGH TO ENSURE THAT THE ALLIANCE HAS ADEQUATE MARKET SHARE TO NEGOTIATE EFFECTIVELY WITH HEALTH PLANS PROVIDING THE COMPREHENSIVE BENEFIT PACKAGE TO ELIGIBLE INDIVIDUALS WHO RESIDE IN THE AREA." IN STATES LIKE MAINE, WHERE A FEW VERY LARGE EMPLOYERS DOMINATE THE STATE, I DON'T KNOW THAT IF THEY WERE TO CHOSE TO ESTABLISH CORPORATE ALLIANCES THAT THE REMAINING INDIVIDUALS WOULD REPRESENT A POPULATION LARGE ENOUGH TO PROVIDE THE ALLIANCE WITH ADEQUATE NEGOTIATING STRENGTH.

WE ARE ALSO CONCERNED THAT FIRMS WILL INITIALLY ESTABLISH CORPORATE ALLIANCES AND THEN FOR FINANCIAL REASONS OR EXPEDIENCY, DECIDE TO PUT THEIR EMPLOYEES IN REGIONAL ALLIANCES. WE WOULD ALSO HAVE TO BE CONCERNED ABOUT ECONOMIC DOWNTURNS DURING WHICH THESE EMPLOYERS MAY LAYOFF WORKERS OR IN THE CASE OF COMPANIES I AM MOST FAMILIAR WITH, SEASONAL LABOR FORCE REDUCTIONS. THE LOCAL IMPACT OF SUCH CHANGES HAVE BOTH BUDGET AND SERVICE DELIVERY IMPLICATIONS. THE

BOTTOM LINE HERE IS THAT WHILE STATES WILL BE HELD ACCOUNTABLE, WE WILL NOT BE ABLE TO ADEQUATELY PLAN. IT WOULD BE SIMPLER AND MORE EFFICIENT TO PUT EVERYBODY IN THE ALLIANCES AND TO ALLOW STATES TO OPT ENTITIES OUT PROVIDED THEY COULD DO SO AND MEET THE REQUIREMENTS OF THE LAW.

WE URGE THE ADMINISTRATION TO PERMIT MORE FLEXIBILITY REGARDING THE DESIGNATION OF ALLIANCE BOUNDARY LINES. I BELIEVE THAT THE ADMINISTRATION SHOULD RECONSIDER THE PROHIBITION ON ESTABLISHING ALLIANCES THAT CROSS STATE LINES. STATES LIKE MAINE MAY BE ABLE TO ESTABLISH MORE EFFICIENT SERVICE DELIVERY SYSTEMS IF THEY WERE PERMITTED TO ESTABLISH ALLIANCES WITH NEIGHBORING STATES. WE ARE ALSO NOT AT ALL CERTAIN THAT THE REQUIREMENT THAT ALLIANCES BE ESTABLISHED BY STANDARD METROPOLITAN STATISTICAL AREAS (SMSA) IS EITHER DESIRABLE OR WORKABLE.

FEDERAL PREEMPTION

THE CLINTON PROPOSAL WOULD PREEMPT A BROAD RANGE OF STATE LAWS. WE BELIEVE THAT ALL FEDERAL PREEMPTION SHOULD BE CAREFULLY SCRUTINIZED. THERE ARE CERTAINLY AREAS WHERE NATIONAL UNIFORMITY IS BOTH NECESSARY AND DESIRABLE, BUT NCSL IS NOT WILLING TO CEDE STATE AUTHORITY IN AREAS WHERE THERE IS NO CLEAR NEED TO DO SO.

FOR EXAMPLE, NCSL SUPPORTS THE ESTABLISHMENT, BY THE FEDERAL GOVERNMENT, OF SEVERAL STANDARD BENEFIT PACKAGES THAT WOULD INCLUDE INSURANCE GUIDELINES AND OPERATING STANDARDS, BUT BELIEVES STATES SHOULD CONTINUE TO REGULATE INSURANCE, INCLUDING SUPPLEMENTAL COVERAGE. THE PRESIDENT'S PROPOSAL WOULD ESTABLISH A FEDERAL CONSUMER PROTECTION FRAMEWORK BY MANDATING THE ESTABLISHMENT OF A STATE HEALTH ALLIANCE GRIEVANCE PROCEDURE. STATE INSURANCE COMMISSIONERS CURRENTLY CARRY OUT THESE DUTIES, AND WE SEE NO REASON TO DUPLICATE EXISTING

STATE EFFORTS THROUGH THE ESTABLISHMENT OF A FEDERAL GRIEVANCE FRAMEWORK OR PROGRAM.

STATES, OVER THE PAST SEVERAL YEARS HAVE ENACTED A BODY OF LAW THAT HAS AT TIMES BEEN CHARACTERIZED AS "ANTI- MANAGED CARE", BUT THEY SHOULD MORE CORRECTLY BE CHARACTERIZED AS LAWS REGULATING MANAGED CARE. THESE LAWS TYPICALLY: (1) REQUIRE LICENSURE OR CERTIFICATION BY THE STATE; (2) ESTABLISH QUALIFICATION AND TRAINING REQUIREMENTS FOR UTILIZATION REVIEW PERSONNEL; (3) REQUIRE AGENTS TO PROVIDE INFORMATION ON HOW DECISIONS ARE MADE; (4) REQUIRE INSURERS TO INVESTIGATE COMPLAINTS; (5) REQUIRES THAT LOCAL STANDARDS OF HEALTH CARE PRACTICE BE USED FOR UTILIZATION REVIEW; AND (6) PLACES THE REGULATORY AUTHORITY FOR UTILIZATION REVIEW AGENTS TO AN APPROPRIATE STATE AGENCY. THESE LAWS SET STANDARDS FOR HOW MANAGED CARE PROVIDERS OPERATE WITHIN THE STATE AND REGULATE UTILIZATION REVIEW COMPANIES, BOTH IMPORTANT FUNCTIONS FOR CONSUMER PROTECTION. THE CLINTON PLAN PREEMPTS THESE LAWS, BUT IS SILENT REGARDING WHAT THE FEDERAL GOVERNMENT WILL DO TO PROTECT CONSUMERS AND ENSURE QUALITY.

THE PROPOSAL WOULD ALSO PREEMPT STATE LAWS WHICH ESTABLISH THE SCOPE OF PRACTICE OF HEALTH PROFESSIONALS LICENSED OR CERTIFIED TO PRACTICE IN THE STATE. THE FEDERAL GOAL OF EXPANDING ACCESS THROUGH THE USE OF PHYSICIAN ASSISTANTS, NURSES, AND ALLIED HEALTH PROFESSIONALS IS ON TARGET, BUT WE BELIEVE PROFESSIONAL REGULATION SHOULD BE THE PURVIEW OF THE LEVEL OF GOVERNMENT THAT LICENSES AND CERTIFIES THE HEALTH CARE PROVIDERS.

ESSENTIAL COMMUNITY PROVIDERS

THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS BEEN GIVEN THE AUTHORITY TO DESIGNATE CERTAIN PROVIDERS AS "ESSENTIAL COMMUNITY PROVIDERS".

Certified health plans would be required to include these providers in their networks initially for a five-year period. This requirement is designed to ensure that providers who have traditionally cared for low income persons, often in underserved areas, will be afforded an opportunity to participate in the new system. NCSL supports this concept.

NCSL policy calls for the inclusion of community health centers, school clinics, public health clinics and other community providers in the network of providers eligible to provide services as long as they meet the established standards and state regulations. The designation of these providers should be a state function in collaboration with local governments. The President's proposal assigns no role in this process for state governments, yet states are responsible for ensuring that the health care delivery systems within their borders are able to provide services to all residents. Primary responsibility for identifying and designating essential community providers should rest with the individual states.

Workers Compensation and Automobile Insurance

The President wants to fully integrate the health component of workers compensation and automobile insurance into the comprehensive reform package. NCSL has no formal position on whether or not they should be included; we believe that states must be assured that the core values, such as broad coverage, safe and healthful workplaces, prompt and high quality health care, are preserved and that neither the liability nor the exclusive remedy doctrine be altered. This area of change needs careful consideration and input from state governments.

Medicaid

We support full integration of the acute care portion of Medicaid. As state legislators, we have extensive experience with the Medicaid program. The program has propped up our weak health care system for a number of years, but does not provide a firm foundation for a new system. True equity in our health care system requires that we decouple health care services from eligibility for cash assistance programs.

We know that if the Medicaid program is fully integrated, some individuals would receive less coverage than they are eligible to receive today under Medicaid. For example, if the Medicaid program in the state where an individual resides covers services not included in the Administration's standard benefit package, they in effect lose benefits. Under the Administration proposal, which only partially integrates the acute care portion of Medicaid into the system, noncash Medicaid recipients would lose this "residual" Medicaid coverage. Individuals who are categorically eligible for Medicaid by virtue of their eligibility for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) would continue to be eligible for and states would be required to provide residual Medicaid coverage.

Building on this approach, the Administration has proposed a new program to provide additional "residual Medicaid coverage" to certain children in low-income households. This new program for children, and this approach in general violates one of the Administration's six principles for health care reform: simplicity. The new children's program has three separate eligibility categories

FOR CHILDREN UP TO AGE EIGHTEEN. THEY INTEND TO FUND THE PROGRAM AS A CAPPED ENTITLEMENT.

IF THE ADMINISTRATION BELIEVES THAT THE COMPREHENSIVE, STANDARD BENEFIT PACKAGE FAILS TO PROVIDE ADEQUATE COVERAGE FOR CERTAIN INDIVIDUALS, ADULT OR CHILDREN, THE ELIGIBILITY SHOULD BE STANDARD AND THE FINANCING SHOULD BE CLEARLY SET OUT. IF THE INDIVIDUALS ARE TO BE ENTITLED TO THESE BENEFITS, THE PROGRAM SHOULD NOT BE CAPPED.

THE ADMINISTRATION MAKES A FEW IMPROVEMENTS TO THE LONG TERM CARE COMPONENT OF MEDICAID. WE ARE GENERALLY SUPPORTIVE. NCSL IS STUDYING THE PROVISIONS OF THE LAW THAT WOULD PERMIT STATES INTEGRATE ALL STATE LONG TERM CARE PROGRAMS INTO ONE. WE ARE CONCERNED THAT INDIVIDUALS WOULD NO LONGER BE ENTITLED TO LONG TERM CARE SERVICES; HOWEVER, SINCE THE PROGRAM IS CAPPED, THAT WOULD PROBABLY BE A NECESSARY CONDITION.

COVERAGE FOR UNDOCUMENTED INDIVIDUALS

WE UNDERSTAND THE PUBLIC POLICY CONCERNS REGARDING COVERAGE OF UNDOCUMENTED INDIVIDUALS; HOWEVER, WE FEEL STRONGLY THAT THE FEDERAL GOVERNMENT SHOULD ADDRESS THIS PROBLEM SQUARELY. AS STATES, WE HAVE NO ABILITY OR AUTHORITY TO CONTROL THE FLOW OF UNDOCUMENTED INDIVIDUALS AND MUST PROVIDE HEALTH CARE TO THESE PERSONS WHEN THEY APPEAR AT THE HOSPITAL OR CLINIC DOOR. WE SHOULD NOT BE LEFT UNASSISTED OR INADEQUATELY ASSISTED, TO PROVIDE HEALTH CARE TO THEM. SOME FUNDING WILL BE SET ASIDE TO REIMBURSE HOSPITALS FOR CARE THEY PROVIDE TO UNDOCUMENTED INDIVIDUALS, AND EMERGENCY CARE THROUGH THE MEDICAID PROGRAM WILL CONTINUE TO BE AVAILABLE. A MORE ADEQUATE AND SPECIFIC RESPONSE TO THIS

PROBLEM IS ESSENTIAL. CERTAIN STATES WILL BE VERY ADVERSELY AFFECTED DUE TO THE LARGE NUMBERS OF UNDOCUMENTED INDIVIDUALS WITHIN THEIR BORDERS.

FINANCING

IT IS ESSENTIAL THAT THE NEW SYSTEM BE ADEQUATELY FINANCED. EVERY EFFORT MUST BE MADE TO AVOID PROMISING MORE THAN CAN BE DELIVERED WITH THE RESOURCES THAT ARE AVAILABLE.

WHILE NCSL HAS TAKEN NO POSITION ON THE ADVISABILITY OF AN EMPLOYER MANDATE, WE BELIEVE THAT, IF SUCH A REQUIREMENT IS INCLUDED IN THE PLAN, SUBSIDIES FOR SMALL, AT-RISK BUSINESSES SHOULD BE PROVIDED. NCSL SUPPORTS MANDATORY PARTICIPATION BY INDIVIDUALS AND BELIEVES THAT SUBSIDIES MUST ALSO BE AVAILABLE FOR LOW-INCOME INDIVIDUALS AND THEIR FAMILIES. THE CLINTON PROPOSAL PROVIDES FOR SUBSIDIES, BUT HAS ESTABLISHED THESE SUBSIDIES AS A "CAPPED ENTITLEMENT", SUBJECT TO THE APPROPRIATIONS PROCESS. WE OPPOSE THIS PROPOSAL. A MANDATE FOR BUSINESSES AND INDIVIDUALS REGARDING PARTICIPATION AND COVERAGE REQUIRES GUARANTEED SUBSIDIES. WITHOUT ADEQUATE SUBSIDIES, UNIVERSAL COVERAGE WILL NEVER BE A REALITY. WE SUPPORT THE PROPOSAL TO PERMIT SELF-EMPLOYED INDIVIDUALS TO ENJOY THE SAME TAX DEDUCTIBILITY BENEFITS AFFORDED TO OTHER BUSINESSES.

THE CLINTON PROPOSAL PROVIDES THAT MOST EMPLOYERS WOULD PAY NO MORE THAN 7.9 PERCENT OF PAYROLL AS A CONTRIBUTION TO THEIR EMPLOYEE'S HEALTH CARE COVERAGE. EXEMPTED FROM THIS "CAP ON PREMIUMS", ARE COMPANIES THAT OPT TO ESTABLISH CORPORATE ALLIANCES, AND STATE AND LOCAL GOVERNMENTS. ACCORDING TO A STUDY CONDUCTED BY THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES (AFSCME), MORE THAN HALF OF THE STATES WOULD EXCEED THE 7.9

PERCENT CAP USING THE ADMINISTRATION'S ESTIMATE THAT THE AVERAGE PREMIUMS WILL BE $4,200 FOR A FAMILY AND $1,800 FOR AN INDIVIDUAL IN 1993. THE MAJORITY OF THE ADVERSELY AFFECTED STATES WOULD BE IN THE SOUTH. TOTAL PUBLIC SECTOR PREMIUMS IN EXCESS OF THE 7.9 PERCENT OF PAYROLL IS ESTIMATED TO BE $1.2 BILLION IN 1997. THE ADMINISTRATION PROPOSES TO BEGIN PHASING-IN THE CAP FOR STATE AND LOCAL GOVERNMENTS IN 2002. THAT IS CLEARLY NOT SOON ENOUGH.

WE ARE CONCERNED ABOUT WHAT WE BELIEVE ARE UNREALISTIC SAVINGS THE ADMINISTRATION HOPES TO SQUEEZE FROM THE MEDICAID AND MEDICARE PROGRAMS. IF THESE SAVINGS CANNOT BE AND ARE NOT REALIZED, THE OVERALL PROGRAM IS NOT ADEQUATELY FINANCED.

FINALLY, THE PRESIDENT'S PLAN AFFECTS STATE TAXES IN A NUMBER OF WAYS. THE PLAN WOULD CONTINUE THE RESTRICTIONS PLACED ON STATES REGARDING PROVIDER-RELATED TAXES; AND IMPOSES A 1.5 PERCENT PREMIUM TAX ON HEALTH PLANS TO PROVIDE SUPPORT FOR GRADUATE MEDICAL EDUCATION. WE OPPOSE THESE PROVISIONS. NCSL FIRMLY BELIEVES THAT WHOM OR WHAT STATES TAX AND HOW THEY TAX IS PURELY A STATE MATTER. THE PREMIUM TAX IS A TRADITIONAL STATE REVENUE SOURCE THAT WE BELIEVE SHOULD NOT BE COMPROMISED.

IN ADDITION, THE PRESIDENT HAS PROPOSED TO INCREASE THE FEDERAL SALES TAX ON CIGARETTES TO 75 CENTS. SIN TAXES ARE ANOTHER TRADITIONAL STATE REVENUE SOURCE. CURRENTLY MANY STATES FUND HEALTH PROGRAMS WITH A PORTION OF THEIR SALES TAX ON CIGARETTES. WE WOULD ASK THAT THE FEDERAL GOVERNMENT INCLUDE THE CIGARETTE TAX REVENUE, WE AS STATES WILL LOSE, AS PART OF OUR FINANCIAL CONTRIBUTION TO THE OVERALL HEALTH CARE REFORM EFFORT.

Transition

Vice President Gore, in his recently released National Performance Review, strongly urges the development of an expedited and expanded waiver process. NCSL strongly supports this proposal. We further believe that, while the federal government debates the details of health care reform, states should be afforded maximum flexibility to begin innovative reform of their health care delivery systems. NCSL supports the establishment and implementation of an expedited waiver process by which states can receive multi-year waivers of requirements under Medicaid, Medicare, ERISA and other federal laws to implement state reforms. ERISA, in particular, in its present form, presents a stumbling block to state efforts to design universal health care coverage systems.

We also support the additional time afforded states to comply with the provisions of the health care reform legislation. States will now have until the end of 1997 to phase-in to the new system. While some states may be able to make the necessary legislative, budgetary, and health care infrastructure changes necessary to fully implement the reform program by 1996, some states will need the additional time. It is critical that each state be able to begin the new program with a firm foundation in place.

Conclusion

In summary, our goal is to be active participants in developing a comprehensive reform strategy to provides for : (1) universal coverage; (2) a strong role for states in program design and implementation under general federal guidance; (3) equity for and between states; and (4) a firm fiscal foundation. We will apply these principles to each health care reform proposal.

I appreciate this opportunity to share our initial views regarding President Clinton's health care reform proposal with you and I look forward to working with all of you over the coming months.

Thank you and I would be happy to answer any questions you may have.

Mr. WAXMAN. Ms. Shipnuck. Just push the button forward.

STATEMENT OF BARBARA SHIPNUCK

Ms. SHIPNUCK. Thank you. Mr. Chairman, members of the subcommittee, I am Barbara Shipnuck, chairwoman of the Monterey County, California Board of Supervisors. I am testifying on behalf of the National Association of Counties and appreciate this opportunity. I will summarize my written statement.

Counties are often the service safety net and are increasingly the Federal and State fiscal safety valve. Over 4,500 health facilities and legal responsibility for indigent care in over 30 States are just two examples of our extensive involvement in health care. I have attached to my testimony a 1-page fact sheet outlining our role.

Our initial analysis of President Clinton's proposal raises some concerns, but we believe it is currently the one that is most consistent with NACo policy.

In the area of essential community providers, we are pleased that the concept of essential community provider is included in the legislation, but are troubled by the lack of specificity for county facility eligibility. Since most local public health departments receive maternal and child health or Ryan White AIDS funds, we assume many of them will receive automatic Federal designation. Left unclear is whether that specific program would be designated or the entire facility and if we would have to do multiple applications.

More troublesome is the lack of any public hospital receiving automatic ECP status. NACo will work to ensure that the top ECP status is strengthened to include specific measures, such as the percentage of low-income persons served by a facility. Without additional statutory guidance, the Department of Health and Human Services may choose to rely upon a health plan's unproven track record in providing care to the poor. This is not a county turf issue because a truly reformed system should not recreate a two-tiered delivery system.

Under capitated payment, however, health plans would have little incentive to reimburse providers that they have no contractual obligation with. Therefore, access to universal coverage, which is the cornerstone of health reform, must be accomplished and a short-term special status will help accomplish that principle.

It is also unclear in the proposal whether incarcerated individuals awaiting trial are guaranteed Federal coverage. Under the legislation, there are conflicting provisions. A prisoner is defined as an adult who has been convicted of a crime, yet in another section health plans are not required to reimburse services provided to detainees in detention facilities.

This issue is also important for the families of detainees. If an employer is no longer obligated to make payments to an alliance for an employee who is awaiting trial because he or she is incarcerated, then the rest of the family's current coverage is also jeopardized and the family could become part of the subsidized pool.

In the area of undocumented immigrants, as local elected officials we recognize the realities of Federal, political politics and any attempt to guarantee benefits to individuals who are in our country illegally. But they have entered due to the lack of Federal enforce-

ment of our immigration policy, and as providers, counties pay for the cost of that failure.

We are pleased that a new provision supports retaining some residual payments under the hospital disproportionate share payment program for those hospitals serving undocumented immigrants and/or high numbers of low-income persons. While the amount of money does not meet the need, it is a step in the right direction. We support this use and the phase-down of disproportionate share only when the uninsured truly have coverage and public hospitals are receiving health plan payments.

There are a number of governance and intergovernmental issues that have similar themes.

There is no recognition of county involvement in creating the State health system reform plan nor is there formal county consultation established for States applying for public health, home and community-based care or mental health access grants. Yet States applying for these funds must assure that their funds and county funds will be maintained. We are also under no illusion that any State will repeal its provision making counties the provider of last resort. If States claim our funds and services, then we must be partners in their initiatives.

The closing of Fort Ord in my community also highlights an additional nuance that we must realize as we go through the health reform effort. In addition to dislocated employees, a significant number of military retirees will continue to live in Monterey County and other communities facing base closures will no longer have the Army medical facilities available to them. This will be true in other communities across the country as well.

Counties so affected will be in the best position to help plan to avoid an additional population facing loss of health services and so we believe counties should be part of the local planning and closely affiliated to the broader State plan for health reform and Federal proposals.

Some counties employing 5,000 or more employees want to have the same option to become their own alliance as similar sized corporations, since they too have successfully managed their own health costs, providing a comprehensive set of benefits.

And our last issue is that counties believe that we must be included in the same payroll cap as private businesses. An employer and its employees should not be treated differently based on whether they are in the public sector or the private sector. Private business has been given assurances that no more than 7.9 percent of their total payroll will go toward meeting their premium contribution for the comprehensive standard benefits, yet public employers will not get that same treatment until the year 2002.

We thank you for this opportunity to testify and I would be pleased to answer any questions.

Mr. WAXMAN. Thank you very much for your testimony.

[Testimony resumes on p. 84.]

[The prepared statement of Ms. Shipnuck follows:]

STATEMENT OF BARBARA SHIPNUCK

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, I AM BARBARA SHIPNUCK, CHAIRWOMAN OF THE MONTEREY COUNTY, CALIFORNIA BOARD OF SUPERVISORS. I AM TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES* AND APPRECIATE THIS OPPORTUNITY.

COUNTY GOVERNMENTS WELCOME THE HEALTH REFORM DEBATE. COUNTIES ARE OFTEN THE SERVICES SAFETY NET AND ARE INCREASINGLY THE FEDERAL AND STATE FISCAL SAFETY VALVE. OUR 4,500 HEALTH FACILITIES AND LEGAL RESPONSIBILITY FOR INDIGENT CARE IN OVER 30 STATES ARE JUST TWO EXAMPLES OF OUR EXTENSIVE INVOLVEMENT IN HEALTH. I HAVE ATTACHED TO MY TESTIMONY A ONE-PAGE FACT SHEET OUTLINING OUR ROLE.

EARLIER THIS YEAR, NACo COMPLETED THE LAST OF EIGHT REGIONAL HEARINGS ON HEALTH SYSTEM REFORM. I PARTICIPATED IN THESE HEARINGS, MEETING WITH THE LOCAL MEDIA AND HEARING TESTIMONY FROM NEARLY 200 WITNESSES. THE MESSAGES WE HEARD THROUGHOUT OUR TRAVELS WERE

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* The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

CONSISTENT: THE NATION MUST ENHANCE LOCAL DELIVERY SYSTEMS EMPHASIZING PREVENTION, PRIMARY CARE AND PUBLIC HEALTH; ADMINISTRATION OF THE SYSTEM MUST BE SIMPLIFIED AND FLEXIBLE; UNIVERSAL COVERAGE, NOT JUST ACCESS, IS IMPERATIVE; AND THE FINANCING OF THE SYSTEM MUST BE BROAD-BASED.

PRESIDENT CLINTON'S PROPOSAL ADDRESSES MANY OF THESE PRINCIPLES. WHILE WE HAVE CONCERNS ABOUT HIS PROPOSAL, WE BELIEVE IT IS CURRENTLY THE ONE THAT IS MOST CONSISTENT WITH NACo POLICY.

I WILL NOW RAISE THE KEY SERVICE DELIVERY, GOVERNANCE AND EMPLOYER ISSUES THAT WILL DEFINE THE COUNTY ROLE AND ITS RELATIONSHIP WITH STATE AND FEDERAL GOVERNMENT.

ESSENTIAL COMMUNITY PROVIDERS

WE ARE PLEASED THAT THE CONCEPT OF ESSENTIAL COMMUNITY PROVIDER IS INCLUDED IN THE LEGISLATION BUT ARE TROUBLED BY THE LACK OF SPECIFICITY FOR COUNTY FACILITY ELIGIBILITY. AUTOMATIC DESIGNATION IS GIVEN TO CERTAIN RECIPIENTS OF FEDERAL DISCRETIONARY HEALTH FUNDS. SINCE MOST LOCAL PUBLIC HEALTH DEPARTMENTS RECEIVE MATERNAL AND CHILD HEALTH OR RYAN WHITE AIDS FUNDS, WE ASSUME THAT MANY OF THEM WILL RECEIVE AUTOMATIC FEDERAL

DESIGNATION. LEFT UNCLEAR IS WHETHER THAT SPECIFIC PROGRAM WOULD BE DESIGNATED OR THE ENTIRE FACILITY.

MORE TROUBLESOME IS THE LACK OF ANY PUBLIC HOSPITAL RECEIVING AUTOMATIC ECP STATUS. CLEARLY, THEY ARE IN THE BUSINESS OF SERVING THE UNINSURED. NACo WILL WORK TO ENSURE THAT THE ECP STATUS IS STRENGTHENED TO INCLUDE SPECIFIC MEASURES SUCH AS THE PERCENTAGE OF LOW-INCOME PERSONS SERVED BY A FACILITY. THAT TYPE OF PROVISION WILL MAKE ECP STATUS FOR A PUBLIC HOSPITAL MORE CLEAR THAN THE RECEIPT OF FEDERAL DISCRETIONARY FUNDS. WE ARE CONCERNED THAT WITHOUT ADDITIONAL STATUTORY GUIDANCE, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES MAY CHOOSE TO RELY UPON A HEALTH PLAN'S UNPROVEN TRACK RECORD IN PROVIDING CARE TO THE POOR.

CLARIFYING ECP ELIGIBILITY WILL BE CRITICAL TO LOS ANGELES COUNTY WHERE OVER $544 MILLION WAS PROVIDED LAST YEAR IN UNCOMPENSATED CARE BY THEIR SIX PUBLIC HOSPITALS, SIX COMPREHENSIVE HEALTH CENTERS AND 40 PUBLIC HEALTH CENTERS.

SOME MAY ARGUE THAT THIS IS A COUNTY "TURF" ISSUE. IT IS NOT. WE SUPPORT THIS DESIGNATION FOR A TRANSITION PERIOD ONLY. A TRULY REFORMED SYSTEM SHOULD NOT RE-CREATE A TWO-TIER DELIVERY SYSTEM. UNDER A CAPITATED PAYMENT,

HEALTH PLANS HAVE LITTLE INCENTIVE TO REIMBURSE PROVIDERS THAT THEY HAVE NO CONTRACTUAL OBLIGATION WITH.

JAIL POPULATIONS

IT IS UNCLEAR WHETHER INCARCERATED INDIVIDUALS AWAITING TRIAL ARE GUARANTEED FEDERAL COVERAGE. BASED ON OUR SYSTEM OF JUSTICE, AN INDIVIDUAL IS INNOCENT UNTIL PROVEN GUILTY. UNDER THE LEGISLATION, THERE ARE CONFLICTING PROVISIONS. A PRISONER IS DEFINED AS AN ADULT WHO HAS BEEN CONVICTED OF A CRIME. YET IN ANOTHER SECTION, HEALTH PLANS ARE NOT REQUIRED TO REIMBURSE SERVICES PROVIDED TO DETAINEES IN DETENTION FACILITIES. THIS OTHER PROVISION WOULD APPEAR TO INCLUDE JUVENILES AS WELL.

THE ADMINISTRATION IS COMMITTED TO ENSURING THAT HEALTH SECURITY CAN NEVER BE TAKEN AWAY. NACo WILL WORK WITH THEM AND THE CONGRESS TO ENSURE THAT PERSONS AWAITING ADJUDICATION DO NOT LOSE HEALTH COVERAGE BECAUSE THEY CANNOT MAKE BAIL.

UNDOCUMENTED IMMIGRANTS

AS LOCAL ELECTED OFFICIALS, WE RECOGNIZE THE FEDERAL POLITICAL REALITIES OF ANY ATTEMPT TO GUARANTEE BENEFITS TO INDIVIDUALS WHO ARE IN OUR COUNTRY ILLEGALLY. AT THE SAME TIME, THEY HAVE ENTERED DUE TO THE LACK OF FEDERAL ENFORCEMENT OF OUR IMMIGRATION POLICY. AS PROVIDERS, COUNTIES PAY FOR THE COSTS OF THAT FAILURE.

WE ARE PLEASED THAT A NEW PROVISION HAS BEEN ADDED SINCE THE SEPTEMBER DRAFT RECOGNIZING THIS PROBLEM. WE SUPPORT RETAINING SOME RESIDUAL PAYMENTS UNDER THE HOSPITAL DISPROPORTIONATE SHARE PAYMENT PROGRAM FOR THOSE HOSPITALS SERVING UNDOCUMENTED IMMIGRANTS AND/OR HIGH NUMBERS OF LOW INCOME PERSONS. WHILE THE AMOUNT OF MONEY DOES NOT MEET THE NEED, IT IS A STEP IN THE RIGHT DIRECTION. WE SUPPORT THIS USE AND THE PHASE-DOWN OF DISPROPORTIONATE SHARE ONLY WHEN THE UNINSURED TRULY HAVE COVERAGE AND PUBLIC HOSPITALS ARE RECEIVING HEALTH PLAN PAYMENTS.

GOVERNANCE/INTERGOVERNMENTAL RELATIONSHIPS

THERE ARE A FEW KEY GOVERNANCE ISSUES THAT NACo HAS IDENTIFIED.

COUNTY ROLE IN STATE PLAN DESIGN

FIRST, THERE IS NO RECOGNITION THAT STATES CREATING NEW HEALTH SYSTEMS MUST CONSULT WITH THEIR POLITICAL SUBDIVISIONS, PRIMARILY COUNTIES, WHICH ACTUALLY DELIVER OR ADMINISTER HEALTH CURRENTLY TO UNINSURED POPULATIONS. COUNTY GOVERNMENTS MUST BE INVOLVED IN THE CREATION OF THE NEW STATE SYSTEMS. IF THERE ARE SYSTEM FAILURES, WE WILL ULTIMATELY PICK UP THE PIECES. WE ARE UNDER NO ILLUSION THAT ANY STATE WILL REPEAL THEIR PROVISIONS MAKING COUNTIES THE PROVIDERS OF LAST RESORT. MEANINGFUL

CONSULTATION MUST OCCUR BETWEEN COUNTY AND STATE OFFICIALS IN DESIGNING NEW STATE SYSTEMS

REGIONAL ALLIANCES

COUNTIES ARE ALSO INTERESTED IN THE DESIGNATION AND MEMBERSHIP OF REGIONAL ALLIANCES. OBVIOUSLY, THERE ARE A NUMBER OF URBAN COUNTIES WHOSE POPULATION OR SIZE EXCEEDS INDIVIDUAL STATES. YOUR HOME COUNTY OF LOS ANGELES, MR. CHAIRMAN, EXCEEDS THE POPULATION OF 42 STATES. THEY HAVE A GOOD UNDERSTANDING OF THEIR OVERALL HEALTH SYSTEM. URBAN COUNTIES SHOULD BE GIVEN THE OPTION OF CHOOSING AN ENTITY TO ADMINISTER A SUBSTATE REGIONAL ALLIANCE.

UNDER THE PROPOSAL, THE BOARD OF THE REGIONAL ALLIANCE WOULD CONSIST OF EMPLOYERS AND CONSUMERS. HEALTH PROVIDERS OR THEIR REPRESENTATIVES ARE SPECIFICALLY EXCLUDED. AS PUBLIC SERVANTS WHO PROVIDE HEALTH TO OUR COMMUNITIES AND ARE MAJOR EMPLOYERS, WE DO NOT BELIEVE THAT THE LEGISLATION INTENDS TO DENY US THE OPPORTUNITY TO SERVE ON REGIONAL ALLIANCE BOARDS. WE WILL WORK TO CLARIFY THAT LANGUAGE.

COUNTY ROLE IN STATE PUBLIC HEALTH GRANTS

WE APPLAUD THE PRESIDENT'S ATTENTION TO PUBLIC HEALTH. A SIGNIFICANT NEW INFUSION OF FUNDS IS PROPOSED. OUR POLICY, HOWEVER, SUPPORTED A SPECIFIC SET-ASIDE FOR

PUBLIC HEALTH. WE ARE CONCERNED THAT AN AUTHORIZATION LEAVES THIS INITIATIVE VULNERABLE. THE GRANTS AVAILABLE FOR CORE PUBLIC HEALTH FUNCTIONS ARE INTENDED TO STRENGTHEN STATE AND LOCAL PUBLIC HEALTH AGENCIES. STATES WILL BID COMPETITIVELY ON ONE OR A NUMBER OF CORE FUNCTIONS. WE URGE THAT STRONG MEASURES BE TAKEN TO ENSURE COUNTY PARTICIPATION IN THE GRANT PREPARATION PROCESS. IF STATES ARE REQUIRED TO IDENTIFY THE AMOUNT OF CURRENT LOCAL FUNDING SPENT TOWARDS A SPECIFIC CORE FUNCTION, THEN COUNTIES MUST HAVE SIGNIFICANT INPUT INTO THE PROCESS. THIS PRINCIPLE ALSO HOLDS FOR THE MENTAL HEALTH AND SUBSTANCE ABUSE ACCESS FUNDS WHICH WILL BE DISTRIBUTED BASED ON STATE APPLICATIONS WHICH MUST DEMONSTRATE THAT NON-FEDERAL FUNDS WILL BE MAINTAINED AT CURRENT LEVELS.

COUNTY ROLE IN STATE LONG TERM CARE GRANTS

STATE AND COUNTY RELATIONSHIPS NEED CLEARER DEFINITION ALSO IN THE HOME AND COMMUNITY-BASED LONG TERM CARE PROGRAM. STATES WILL BE GIVEN FLEXIBILITY IN SPECIFYING THE TYPES OF SERVICES AND PAYMENTS FOR THE PROGRAM. AN ADVISORY GROUP WOULD BE SET UP IN EACH STATE ESTABLISHING AND MAINTAINING THE SYSTEM. DESPITE THE SIGNIFICANT ROLE COUNTY GOVERNMENTS ASSUME THROUGH THEIR AREA AGENCIES ON AGING AND DISABILITY-RELATED SERVICES, COUNTIES ARE NOT MENTIONED AS SERVING ON THE STATE ADVISORY GROUP.

ENABLING SERVICES

COUNTIES ARE CONCERNED ABOUT THE PERMISSIVE LANGUAGE GIVING STATES THE OPTION TO PROVIDE FISCAL INCENTIVES TO HEALTH PLANS TO ENROLL AND SERVE DISADVANTAGED GROUPS. STATES ALSO MAY PROVIDE FUNDS FOR EXTRA NON-MEDICAL SERVICES TO ENSURE ACCESS SUCH AS OUTREACH, TRANSPORTATION AND INTERPRETING SERVICES.

IN ANOTHER SECTION OF THE BILL, THERE ARE AUTHORIZATIONS UNDER THE PUBLIC HEALTH SERVICE INITIATIVE TO SUPPORT ENABLING SERVICES AND TO CREATE PUBLIC OR NON-PROFIT HEALTH PLANS WHICH SERVE SIGNIFICANT NUMBERS OF THE MEDICALLY UNDERSERVED.

SINCE WE SEE THE CURRENT SYSTEM DISARRAY AT THE LOCAL LEVEL, WE BELIEVE THAT THERE IS A POTENTIAL FOR FAILING TO REACH DISADVANTAGED POPULATIONS UNDER THIS DESIGN. STATES WILL BE UNDER TREMENDOUS PRESSURE TO FULFILL THE NEW REQUIREMENTS OF THE SYSTEM. IT IS UNLIKELY THAT THEY WILL ACT ON AN OPTION TO PROVIDE ENABLING SERVICES SINCE THEY WILL ASSUME A SEPARATE POOL OF FEDERAL MONEY MAY BE AVAILABLE, OR, AS A LAST RESORT, COUNTIES WILL FILL IN THE GAPS.

THERE MUST BE GREATER ASSURANCES THAT ENABLING SERVICES FUNDS WILL BE AVAILABLE TO HEALTH PLANS OR ESSENTIAL COMMUNITY PROVIDERS. THE CURRENT STATE OPTION AND A POSSIBLE FEDERAL AUTHORIZATION LEAVE TOO MANY CHANCES FOR FAILURE. PERHAPS A SPECIFIC SET-ASIDE WITHIN THE REGIONAL ALLIANCES WOULD GIVE GREATER CERTAINTY THAT THESE CRITICAL SERVICES ARE PROVIDED.

EMPLOYER ISSUES

COUNTIES ARE MAJOR EMPLOYERS, PROVIDING HEALTH COVERAGE TO ABOUT TWO MILLION EMPLOYEES. WE ARE CONCERNED ABOUT THE SEPARATE TREATMENT OF PUBLIC EMPLOYERS COMPARED TO THEIR PRIVATE COUNTERPARTS.

SOME COUNTIES EMPLOYING 5,000 OR MORE EMPLOYEES WANT TO HAVE THE SAME OPTION TO BECOME THEIR OWN ALLIANCE AS SIMILAR SIZED CORPORATIONS. THEY HAVE SUCCESSFULLY MANAGED THEIR OWN HEALTH COSTS PROVIDING A COMPREHENSIVE SET OF BENEFITS. THEY ASK TO BE TREATED THE SAME AS A LARGE BUSINESS.

CONSISTENT WITH THIS PHILOSOPHY IS COUNTY GOVERNMENT'S POSITION THAT THEY BE INCLUDED IN THE SAME PAYROLL CAP AS BUSINESS. AN EMPLOYER AND ITS EMPLOYEES SHOULD NOT BE TREATED DIFFERENTLY BASED ON WHETHER THEY ARE PUBLIC SERVANTS OR ARE IN THE PRIVATE SECTOR. PRIVATE BUSINESS HAS BEEN GIVEN ASSURANCES THAT NO MORE THAN 7.9 PERCENT OF THEIR TOTAL PAYROLL WILL GO TOWARD MEETING THEIR PREMIUM CONTRIBUTION FOR THE COMPREHENSIVE STANDARD BENEFIT. YET, PUBLIC EMPLOYERS WILL NOT GET THAT SAME TREATMENT UNTIL THE YEAR 2002. AGAIN, THE OPTIONS AND FLEXIBILITY GIVEN TO EMPLOYERS AND THEIR EMPLOYEES SHOULD NOT BE DETERMINED BY WHETHER THEY ARE PUBLIC OR PRIVATE ENTITIES.

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY. I WILL BE HAPPY TO ANSWER ANY QUESTIONS.

NATIONAL ASSOCIATION OF COUNTIES

"Counties Care For America"

440 First Street, N.W. • Washington, D.C. 20001 • 202/393-6226

THE COUNTY ROLE IN TODAY'S HEALTH SYSTEM

County government's broad perspective on the health system is unique due to the range and magnitude of its functions.

FUNCTIONS

1) Public Health - Counties work to ensure the well-being of the entire community through public health services, with a strong focus on cost-effective screening and preventive services.
2) Provider/Administrator - Counties administer and provide services directly to the community, including those mandated by the federal and state governments.
3) Payor - Counties assure access to the health care system for their employees by providing or purchasing health insurance.
4) Purchaser - Counties purchase health services from other providers with local tax dollars.

MAGNITUDE

- Counties are responsible for spending approximately $30 billion on health and hospital services annually.
- Counties provide care for approximately 40 million people who access local health departments.
- Counties are responsible for at least 4,500 public health facilities including hospitals, nursing homes, clinics, health departments and mental health clinics.
- Counties spend approximately $680 million annually on capital outlay for hospital construction, maintenance and equipment.
- Counties purchase health care for over 2 million employees.
- Counties are legally responsible for indigent health care in more than 30 states.
- Counties are required to pay a portion of the non-federal share of Medicaid in more than 20 states.
- Counties deliver AIDS services, including care in the majority of the 24 highest caseload areas receiving emergency funds under the Federal Ryan White CARE Act.
- Counties are often the focus of prevention services with more than 90% of county health departments active in tuberculosis screening, immunizations and child health services.
- Counties provide training for 26 % of the nation's physicians in major public teaching hospitals.

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Mr. WAXMAN. I want to express my appreciation to the three of you for giving us your views.

Let me ask this: Under the President's plan, the Federal subsidies for low-income people for small employers, for early retirees are capped each year. In the first year of implementation they cannot exceed $10.3 billion, over the first 5 years they cannot exceed $274 billion. My question is what happens if the administration's estimates are wrong and the Federal subsidy cap is breached in a given year? Who ends up holding the bag?

It looks to me as though it is the States. The Federal subsidies flow to the regional alliances. If the subsidies are not sufficient to enable an alliance to pay its health plans, the amount needed to provide the coverage to which people are entitled, the alliances really have no place to turn but the States. The Federal contribution is capped, the employer contribution is capped, and premiums are capped. Since the alliances are creatures of the State and since they do not have their own taxing authorities, are the States not ultimately liable, and what is your interpretation, Mr. Scheppach?

Mr. SCHEPPACH. In all honesty, I think it is unclear. We are concerned about this. It seems to me in the language that the States are responsible to assure that health care is delivered. And if that is, in fact, true, and there is no money available, then you can make a case that the States are in fact at risk.

One of our concerns is with respect to the potential type budgets as well. I think the language right now is a little bit unclear. When we pushed the administration on this issue, they told us that you would cut the benefit levels. But given that the benefits levels are going to be in legislation, I think that that is tough. So it is unknown at this time.

Mr. WAXMAN. Ms. Shipnuck, I was struck by your statements that the counties are under no illusion that any State will repeal their provisions making counties the providers of last resort. If I understand you correctly, you fear it is the counties, not the States, that will be holding the bag if Federal subsidies for lower income people and small businesses fall short of what regional alliances need in order to guarantee coverage for all.

How do you see this playing out?

Ms. SHIPNUCK. I think that is exactly on target, Mr. Chairman. I think that we recognize that as long as we are the providers of last resort and we are the providers for indigent care for undocumented aliens, for jail populations, for anybody whose safety net is then removed that we would be under the obligation to make up any shortfall, either as direct providers or as payers, and that is quite clear in the law of at least 32 States.

Mr. WAXMAN. Ms. Rydell, do you think it will be the States or the counties who will end up holding the bag?

Ms. RYDELL. In my State it will certainly be the State because we have minimal county government and no county services except for law enforcement. So that it is clear it would be the State.

We are very concerned about that because we feel that subsidies are essential; that small at-risk businesses and individuals will need a subsidy if they are to be a part of the system. And if we truly want universal coverage, then we have to make it affordable.

However, it is unclear to us, and we are very concerned about that lack of clarity, because what is clear to us is that we could not afford, as an individual State, and my colleagues that I talk with around the country are saying the same thing, to be able to bear that burden. Because it would be an unequal burden also, because in terms of the number of people and the number of businesses needing subsidies, that will clearly vary State by State.

Mr. WAXMAN. Under the President's plan, a State has the discretion to draw the boundaries for regional health alliances, but in doing so may not subdivide metropolitan statistical areas, or MSA's. We have heard testimony in opposition to this requirement, which is intended to prevent States from discriminating against high-risk, low-income communities, and we have been asked for the flexibility to draw boundaries that include rural areas with part of an MSA.

Why? I would like to know will rural areas be disadvantaged under the President's proposal? If so, how? And can you give us some concrete examples of the kinds of boundaries the States would draw under your proposal? Mr. Scheppach.

Mr. SCHEPPACH. Yes, I just think it is going to be difficult to get the same number of providers to enter a rural area as in a urban area. You will probably have to do a little quid pro quo, with accountable health plans basically saying that you can come into this part of the urban area if you also will in fact service the particular rural area.

So I can see in some areas where you have—let's use the example of Richmond. It may be that you might want to divide Richmond—I am not even sure that is an SMSA, but I will use it as an example. You may want to put part of Richmond with the area that goes sort of to the southeast of it into that rural area so that you will have coverage, which means you have high quality hospitals that are in the same plan as rural clinics.

So I think you will limit that possibility and I think potentially hurt care in rural areas. That is where we would need at least a waiver provision. We agree with the intent of the legislation and we are just hopeful that a better way can be found.

Mr. WAXMAN. As the testimony in this hearing today makes clear, the President's plan confers enormous responsibility upon the States. One of the most critical State responsibilities has to do with access to care. The President would require each State to ensure that everyone has "adequate access to enroll in a choice of regional alliance health plans." To the maximum extent practicable, this choice must include a plan with premiums at or below the weighted average of the region.

Obviously, if Americans do not have adequate access to enroll in a choice of plans, then the entitlement to comprehensive coverage is basically meaningless. The President has recognized this and is proposing to hold the States accountable. To ensure accountability he would permit individuals to bring private rights of action against States that fail to carry this out and all other responsibilities that they have under the plan.

I think, Mr. Scheppach, you testified against these proposals. As I read it, you do not want to be responsible for assuring access and you do not want to be held accountable for failure to perform. My

question is who do you think should be held responsible and how should Americans be able to hold them accountable?

Mr. SCHEPPACH. I think the problem, Mr. Chairman, is the interaction between the potential guarantee funds, the global budget and who is ensuring access. I can see a scenario where you have a global budget that is only going to be increasing at 4 percent; is that some plans and some alliances go under and go to the guarantee fund first and if you don't have enough money in the guarantee fund come back to States for funding.

So I think that what concerns us is a little bit, if this is a true Federal-State partnership, it seems to me the Federal Government is setting the benefit package for all practical purposes as a floor and they are also setting the global budget which is the ceiling and it is up to the States to be accountable really for any shortfall. I think there is a fair amount of risk there. And if you add to that the ability for individuals to sue in court for that, I think it is a very difficult situation.

Mr. WAXMAN. Would you want to comment on that, Ms. Rydell?

Ms. RYDELL. Yes, this is a provision we are studying very carefully and in conjunction also with the National Association of Attorneys General. We believe that a national health plan and State plans should reduce the amount of litigation, not proliferate that.

We certainly were glad to see the ombudsman and other kinds of consumer complaint resolution systems that would be set up, but we were disturbed to see that particular provision. Because if individuals are allowed to bypass any other provisions and go directly to court, that could potentially increase the amount of litigation and puts an adversarial relationship into this new system.

However, I think that in terms of ensuring access, that there is going to have to be a great deal of flexibility for States, and it is tied in with, for example, our being able to define alliance boundaries and our being able to, not only just outside a standard metropolitan statistical area, but also, as I said, across State lines. If we really want access, we have to give the flexibility that would be appropriate in a particular geographic region to put into place the appropriate choices for individuals.

Mr. WAXMAN. Yes, Ms. Shipnuck.

Ms. SHIPNUCK. Thank you, Mr. Chairman. One of the reasons we feel so strongly the essential community provider designation should be a Federal designation during the transition period goes to the very heart of your question. What we cannot afford—while we are beginning to focus on how we train people to accept new forms of access or go into different plans that may become available, we must maintain and be certain that the existing safety net, which is the only one that they get any service from currently while they are uninsured and underserved, remains intact.

We think that is a critical transition period issue and goes to the heart of how we go through framing the new health reform system and minimizing the kinds of lawsuits you have described. It would be a tragedy to have a designation, have some traditional folks have to sue and waste everybody's time and money at a time that we are trying to bring more providers on line rather than fewer providers.

Mr. WAXMAN. Thank you very much. I appreciate your testimony and we certainly are going to have to work closely together as we move this legislation forward. Thank you.

Mr. SCHEPPACH. Thank you.

Ms. RYDELL. Thank you, Mr. Chairman.

Ms. SHIPNUCK. Thank you.

Mr. WAXMAN. Our second panel includes representatives of private purchasers of care and managed care plans that operate on a multistate basis. We are interested in their views on the implications of the broad regulatory discretion conferred on the States under the President's plan.

Mr. Alan Peres is the Manager of Benefit Planning at Ameritech Inc.; Mr. James S. Ray is an attorney with the firm Connerton, Ray, and Simon and is presenting the testimony of Robert Georgine, President of the Building and Construction Trades Department of the AFL-CIO; Ms. Karen Ignagni is President and Chief Executive Officer of the Group Health Association of America; and Ms. Alissa Fox is Executive Director, Congressional Relations of the Blue Cross/Blue Shield Association. Ms. Fox is substituting for Ms. Lehnhard who, unfortunately, is ill today.

Let me thank you all for being here. We very much look forward to your testimony. Each of you will have your written statements in the record in full, so what we want to do is ask each of you to limit your oral presentations to no more than 5 minutes.

Mr. Peres, we will start with you.

STATEMENTS OF ALAN PERES, MANAGER, BENEFIT PLANNING, AMERITECH, INC.; JAMES S. RAY, ON BEHALF OF BUILDING AND CONSTRUCTION TRADES DEPARTMENT, AFL-CIO; KAREN IGNAGNI, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA; AND ALISSA FOX, EXECUTIVE DIRECTOR, CONGRESSIONAL RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. PERES. Thank you, Mr. Chairman, members of the subcommittee, I am Alan Peres, Manager of Benefit Planning for Ameritech. I am testifying today on behalf of the Association of Private Pension and Welfare Plans, a nonprofit organization whose members include large and small health employee benefit plan sponsors and organizations providing support services to those plans.

It is the first national employer organization to endorse an employer mandate. We have also endorsed development of more efficient health care delivery systems and health plan competition on the basis of cost and quality.

This morning I will address the role of the States in health care reform and discuss our concerns about the employer's role based on our commitment to maintain and improved employment-based health benefits.

Ameritech is a telecommunications and information services company headquartered in Chicago primarily serving the Great Lakes area. To better serve our customers, we are being transformed from an organization primarily along State geographic line organizations to units which will meet our market demands regardless of the location being served.

Uniformity across State lines is vital to develop and implement medical plan management strategies across our company. We believe the employment-based system provides the strongest foundation for achieving universal coverage, cost containment, and quality improvement.

Employment-based health benefits are changing rapidly, with increased emphasis and success in improving the quality of care and service our employees receive while limiting cost increases. Yet, for practical purposes, the President's plan would eliminate employers of all sizes as active purchasers of health benefits. This is due to several factors, including the nature of the regional alliances and the level of State flexibility.

Regional alliances could cover as much as 90 percent or more of the non-Medicare market. The few employers not required to join the regional alliance would lose the leverage needed to influence the way health plans perform. In addition, they will be subject to a variety of taxes and rules and ineligible for subsidies available to those in their regional alliances.

Nationally uniformed rules are necessary for establishing a competitive health market and promoting efficient administration of multistate health plans whether looking at that from the employer perspective or from the perspective of the delivery systems themselves. The principle of the President's designation of the Secretary of Labor for responsibility of enforcement of corporate alliance provisions at the national level should be followed in other areas as well.

National uniformity is important to us as multistate employers. State flexibility will impact us in many ways. Varying benefit levels will force us to level up to the highest level of benefit across our States. Varying State rules will limit our choices of national networks of providers, increase administrative complexity, and multiply the number of plans with which we must contract.

State regulation of smaller employers and health plans affect us directly, as we use the same networks and reimbursement methods available to an entire plan's book of business. We have many interstate labor markets and health care markets. Maryland residents, for example, seek care not just in Maryland but the District of Columbia, Virginia, Delaware, and Pennsylvania. At Ameritech, we have several thousand employees who live in one State and work in another.

Lack of Federal uniformity will set up a series of conflicting or incompatible State rules that will not be correctable through administrative actions of a company benefits department but only through government legislation or regulation following lengthy hearings. In the meantime, our employees and your constituents will be left in the lurch.

We oppose State flexibility for the following reasons: Many States have been deeply hostile to cost containment initiatives passing antimanagement's care laws. The President's plan recognizes States' hostilities by preempting these laws. We have concerns some States will be unable to administer complex health programs, and we are not alone in our concerns. Our spokesperson for the AARP recently said something very similar.

The creation of a State or sub-State variations from national rules will create a problem. An employer doing an excellent job of managing benefits in several States could be forced into regional alliances if a single State chooses a single payer option. States will be given jurisdiction over claims appeals from corporate alliances. We will face 50 different legal standards rather than the current single ERISA standard.

A State-run regional alliance could not replicate the range of cost containment and quality improvement initiatives undertaken by multiple active purchasers. Performance standards, whether local or national, will become ceilings rather than floors as they currently are in our dealings.

Last, States can require contracting with essential community providers. Government has a legitimate interest in assuring that health plans offer enrollees appropriate access, however, health plans should be accountable for providing appropriate access to care, not care from specified providers.

A mandated contract does not guarantee use of an essential provider. We are in need of a financing mechanism other than mandated contracting to assure the viability of efficient and essential community providers.

In summary, we accept that private purchasers will have to comply with government's mandated changes and the way they operate. However, nationally uniform rules are especially important to the effective operation of an employment-based system. We would be pleased to work with the subcommittee and the administration to craft nationally uniformed rules that are acceptable to both multistate employers and the States.

Thank you, Mr. Chairman. I would be pleased to answer any questions that you may have.

Mr. WAXMAN. Thank you very much, Mr. Peres.

[The prepared statement of Mr. Peres follows:]

ALAN PERES
MANAGER BENEFITS PLANNING
AMERITECH, INC.

I. Introduction

Mr. Chairman, members of the Subcommittee, I am Alan Peres, Manager, Benefit Planning for Ameritech, Incorporated. On behalf of the Association of Private Pension and Welfare Plans (APPWP), I am pleased to offer comments on the states' role under President Clinton's health reform plan. Mr. Chairman, at this time I ask that the full text of my remarks be entered into the record in order that I may proceed with my oral statement.

APPWP is the first national organization of employers to endorse a requirement that employers offer health benefits to their employees and pay most of the premium. We have also endorsed measures that would contain costs by promoting the development of more efficient health care delivery systems and encouraging consumers to choose between competing health plans on the basis of cost and quality, among other steps.

The APPWP is a nonprofit organization whose members include large and small health and employee benefit plan sponsors and organizations providing support services to those plans. Our members directly sponsor or administer employee benefit plans such as pension and health benefit plans covering over 100 million Americans.

APPWP commends President Clinton for putting the prestige of his office behind the effort to reform the nation's health system. His introduction of the "Health Security Act of 1993," has irreversibly set the country down the road toward passage of health reform legislation. Moreover, the Act includes many positive features and has made several revisions to the draft proposal which we view as important. Nonetheless, APPWP has reservations about the President's plan which I will outline below. Although the 1,342 page plan has only been available since last week I will endeavor today to point out were we find merit with the President's plan but also in areas were we can be constructive, point out were we think changes should be made.

This morning, I will address the role of the states in health care reform and discuss our concerns about the employers' role under the President's plan. Our views about state flexibility are closely related to our commitment to maintaining and improving employment-based health benefits. Today, I will focus on the flexibility states would have to opt-out of the national health reform rules under the President's plan. I also will focus on the new roles states are given under the President's plan by virtue of their authority over health alliances. Before proceeding to these topics, I will outline the practical situation which Ameritech faces as a multistate employer providing health benefits.

II. Health Benefits at Ameritech

Ameritech is a telecommunications and information services company headquartered in Chicago. Our primary service area is the states of Wisconsin, Illinois, Indian, Ohio and Michigan. Ameritech's benefits cover 50,000 active and 70,000 retired employees and their dependents, approximately 250,000 people in all. Approximately 75% of our active employees are union represented.

Our company has recently moved from subsidiaries organized primarily along state geographic lines to units organized to meet market demands regardless of the state or local area being served.

Most of our active employees, and a growing number of retired employees are in a point-of-service company-sponsored managed care plan. Those not in network areas are in plans with preferred provider organization (PPO) options. We also offer our workforce an HMO option.

Our medical benefits are managed by Blue Cross and Blue Shield of Illinois (BCBSI). BCBSI subcontracts with four other Blue Cross organizations for local medical network management.

Uniformity across state lines is vital for Ameritech to be able to develop medical plan management strategies which can be applied across the board and company-wide.

III. The President's Plan's Treatment of Employment-Based Health Benefits

APPWP's concerns about the role of the states are most acute if Congress retains an employment-based health benefits system for working Americans. APPWP firmly believes that health reform legislation should build on, rather than dismantle, employment-based health benefits. However, the APPWP also has serious concerns about a system which allows for a state opt-out option even if employers pay for but do not buy coverage.

The current employment-based system is not perfect; it could be markedly improved by health reform legislation. Nonetheless, it provides the strongest foundation for achieving universal coverage, cost containment and quality improvement. Eliminating rather than strengthening employers' role as active purchasers of health benefits would lead to a less affordable and lower quality health care system for an increasing number of Americans.

These cost containment initiatives are beginning to bear fruit. The medical component of the Consumer Price Index and a recent study of employer-sponsored health plans by KPMG Peat Marwick indicate that health cost increases--while still too rapid--are slowing. Employers are limiting cost increases even though Medicaid and Medicare cost-shifting adds several percentage points

to the annual increase in employers' health benefit costs.

A. Reforming Employment-based Health Benefits. Employment-based health benefits are changing very rapidly. The fast-moving trends favor increasing effectiveness at cutting costs and improving quality. These trends would be accelerated if reform legislation creates mechanisms which both enhance large employers' cost management tools and give smaller employers the same opportunity to actively purchase health benefits as larger groups. Yet for practical purposes the President's plan would eliminate employers' as active purchasers of health benefits.

For example, all employers with fewer than 5,000 employees would be required to purchase health benefits through state-run or state-chartered regional alliances. These employers would not have a direct role as purchasers.

B. Scope of the Alliances. Nearly all employers with more than 5,000 workers would have little choice but to take their option to join a regional alliance. Regional alliances could cover 90% or more of the non-Medicare market. The few employers not required to join the regional alliance would lack the leverage needed to negotiate changes in the way health plans deliver care. Also, employers outside the regional alliance would be vulnerable to cost-shifting, ineligible for subsidies available to employers who join the alliance, subject to taxes not levied on employers joining the alliance, and required to comply with rules restricting cost management strategies.

State management of regional alliances also raises questions about the viability of corporate alliances. Since regional alliances would cover such a large portion of the market, the quality of state management would effectively determine how well corporate alliances can manage their own plans. Additionally, state management of regional-alliances creates opportunities for cost-shifting onto corporate alliances.

A state-run regional alliance is no substitute for multiple employers actively purchasing health benefits. No single entity could replicate the range of cost containment and quality improvement initiatives undertaken by multiple active purchasers. Additionally, a government entity is less likely than private purchasers to make the tough choices needed to cut costs and improve quality, since doing so could generate intense political opposition. For instance, the President's plan would require fee-for-service offerings, even though many employers are moving away from such options.

IV. The Importance of National Uniformity

Nationally uniform rules establishing a competitive health care market are essential to the private sector's ability to cut costs

and improve quality.

One positive aspect of the President's plan with respect to national uniformity is the provision designating the Secretary of Labor responsible for enforcing the Corporate Alliance provisions rather than allowing the states to enforce these standards. We think this makes good sense and hope that Congress expands on this notion of nationally uniform standards as the legislation wends its way through the legislative process. Additionally, the President's plan does not permit state waivers from federal standards on a provisions-by-provision basis. We think this, too, makes good sense.

Nationally uniform rules are necessary for the efficient administration of multistate employers' health plans.

A. Efficient Administration of Health Benefits. The United States has already experimented with governing multistate employers employee benefit plans including health plans under state-by-state rather than nationally uniform rules. In response to that failed experiment Congress passed the Employee Retirement Income Security Act (ERISA) in 1974, in part, because of its experience with inconsistent state regulation of pension and health plans.

ERISA's framers specifically addressed the extent to which the Act's comprehensive federal standards should supersede state law. Each of the House and Senate-passed bills would have limited the preemption of state laws to those laws relating to the specific subjects addressed in ERISA. However, the ERISA conferees rejected these narrower preemption standards in favor of superseding "all" state laws that relate to employee benefit plans.

ERISA's sponsors emphasized the importance of avoiding a piecemeal, state-by-state approach to regulation and the APPWP believes this Congress and this Administration would be wise to take this approach to the role of the states as well. Clearly, the case for national uniformity is even more compelling today than it was in 1974, due to the growth of network-based managed care plans and active purchasing by employers.

Uniformity allows multistate employers to cover all of their workers by negotiating contracts with a limited number of health plans. State opt-outs from national rules or allowing states to vary how national rules are implemented, as proposed under the President's plan, could prevent some health plans from operating in some states, thereby multiplying the number of plans a multistate employer must contract with in order to cover all of its workers. This would add to administrative costs and complexity, while reducing the employer's bargaining leverage and ability to manage relationships with health plans.

Even if a health plan is permitted to operate in all states or

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regions of concern to a particular employer, differing requirements regarding plan features such as benefits, quality reporting, data reporting or provider reimbursement would add to administrative costs and complexity. It is important to recognize that allowing states to vary health system rules only as they relate to smaller or single-state employers creates nearly as many administrative problems as allowing states to directly regulate large, multistate employer plans.

Rules governing the majority of the market will define the range of possibilities available to multistate employers. For instance, if a state is permitted to establish a single payer system for all persons except those covered by multistate employers, in practical terms it would not be possible for multistate employers to offer its workers in that state the same type of network-based coverage offered to its workers in other states.

B. Labor-Management Relations. Nationally uniform rules are an important element of labor-management relations. Multistate employers must be able to offer the same health benefits to all workers, regardless of the state they work in. If one state is permitted to vary the terms of coverage -- for instance, the scope of benefits -- multistate employers' employees inevitably will seek arrangements available to their co-workers. This is likely to occur even if the employer is not required to pay directly for the more permissive arrangements mandated by a particular state. The President's plan states that "if a participating State provides benefits (either directly or through regional alliance health plans or otherwise) in addition to those covered under the comprehensive benefit package, the State may not provide for payment for such benefits through funds provided under this Act." We would feel more comfortable if this language were changed to an outright prohibition on states increasing the benefits package given our discouraging experience with state mandated benefits.

Additionally, multistate employers may be hindered in their ability to transfer employees between states because of state health plan variations. For instance, an employee living in one state who derives personal reassurance by his employers' negotiated quality arrangements may be reluctant to transfer to a single payer state because it would eliminate his employers' role as an active purchaser of health benefits. Notably, polls show that far more workers trust their employer than their state government to arrange for their health coverage.

C. Interstate Health Care and Labor Markets. Many individuals cross state borders to receive health care services. For instance, many residents of the New England states receive care in Massachusetts; Maryland residents routinely receive care in Virginia, the District of Columbia, Delaware and Pennsylvania; and residents of some mountain states such receive much of their care in Colorado and Utah.

Inconsistent state plans in interstate health markets would cause serious problems for plans covering the many thousands of employees who cross state lines to obtain health care. For example, at Ameritech we have several thousands of employees that live in one state and work in another. If neighboring states adopt differing policies toward key health system components, it will be difficult for employers and health plans to organize efficient, high quality health care across state borders. Both payers' and providers' administrative costs would increase. Efforts to restructure the health care delivery system could be hampered since providers could face differing incentives based solely on their patients' state of residence.

D. State Barriers to Private Sector Cost Containment Initiatives. Many states have demonstrated a deep hostility to the private sector's cost containment initiatives. State mandated benefits, anti-managed care and anti-managed pharmaceutical laws, and excessive restrictions on mid-level practitioners have prevented private initiatives from reaching their full potential to cut costs and improve quality. These laws would have had an even more destructive effect on private sector initiatives if ERISA did not preempt most of them from applying to self-insured health benefit plans. We think the President's plan appropriately recognizes state hostility toward managed care plans by preempting these laws.

Additionally, some states may be unable to administer complex health programs. Few state Medicaid programs are models for the type of health care system Americans want. Even some of the states which are highly regarded for their governments' technical proficiency have had obvious problems in regulating the insurance market. And many states did a poor job of implementing rather simple federal standards for reforming the Medigap market.

We are not alone in our skepticism regarding the role of the states in this regard. Recently, a spokesperson for the American Association of Retired People (AARP) said, "We are not convinced that states would be able to develop and maintain the consistent, high standards with respect to oversight and enforcement that would be necessary to support a takeover of the Medicare program [regional alliances]." If state administration is not adequate for elderly persons, neither is it adequate for non-elderly individuals.

V. State Opt-Outs Under the President's Plan

The President's plan creates a number of opportunities for states either to vary from national health reform rules, or to set their own courses within those rules.

A. Single Payer Option for All or Part of a State -- States could require all employers, regardless of size, to participate in a single payer system. The single payer system could cover all or

part of a state. For many of the reasons discussed above -- e.g., the imperatives of labor-management relations in multistate firms and the interstate character of many health care and labor markets -- a state single payer option would create serious problems for multistate employers. Allowing single payer areas within states would further increase administrative costs and confusion for employers, health plans, patients and providers.

The state single payer option creates an additional problem for multistate employers. Employees residing in single payer states would not count for purposes of determining whether an employer is large enough to form a corporate alliance under the President's plan. An employer doing an excellent job of managing benefits in several states could be forced into regional alliances if a single state chooses a single payer option, thereby bringing the number of workers covered by the employer below the threshold level for establishing a corporate alliance. Interstate labor markets compound the problems that would be caused by inconsistent single payor systems.

Finally, it is unreasonable to expect employers to invest in effectively managing benefits when employers' role in covering workers is subject to ever-changing political fashions in each state.

B. Mandated Contracting with "Essential Community Providers." States can require self-insured and insured health plans to contract with independent health professionals and health care institutions in underserved areas that the federal government designates as "essential community providers." Government has a legitimate interest in assuring that health plans offer enrollees appropriate geographic access. However, this particular approach could insulate providers from market pressure to improve cost and quality performance and deny health plans the opportunity to manage costs as effectively as possible. Health plans should be accountable for providing appropriate access to care, not care from state-specified providers.

Essential community providers must be paid either at a capitated rate no lower than the rate paid to other providers for the same services or rates based on Medicare payment principles. This does not solve the cost management problem for health plans. Adding to the size of provider networks increases the plan's management costs and reduces the plan's opportunity to negotiate favorable arrangements with other providers. Additionally, the required payment methodologies may not mesh with how the plan pays other providers and does not take account of quality.

Allowing states to require health plans to contract with specified providers also raises serious conflict of interest problems. Many essential community providers may be state-sponsored institutions.

C. Mandating Additional Benefits. States are permitted to add benefits to the national package, so long as they do not rely on funds provided under the Health Security Act. State variations in benefits would burden multistate employers. Workers in one state are likely to seek the benefits received by their co-workers in other states particularly if employers are taxed to pay for additional benefits. We believe that states should not be permitted to mandate benefits not included in standardized national packages.

D. State Administration of New ERISA Title. The President's plan would greatly expand the role of states with respect to claims adjudication available to plan participants in corporate alliances. We have grave concerns regarding the expansion of remedies under ERISA. Because the focus of today's hearing is the state's role in health reform, we will comment only on our concerns about adjudication of claims by the states.

State adjudication is likely to lead to different standards governing claims denial, vastly complicating benefits administration for multistate employers. Moreover, states may have a conflict of interest in adjudicating claims against corporate alliances. While appeal is available to a federal agency and the federal courts, cost and other practical factors prevent such appeals from resolving problems related to state-by-state claims adjudication.

E. State-Determined Fee Schedules. The President's plan mandates that each fee-for-service health plan (and the fee-for-service portion of network-based plans), including plans which corporate alliances are required to offer, make payments in the amounts provided under the fee schedules established by regional alliances. Because many employers are on the cutting edge of cost containment, it makes little sense to allow the state-run regional alliances to dictate the terms of the fee schedules for the corporate alliances. There is no evidence the state-run regional alliances would do a better job of setting and negotiating fee schedules than the corporate alliances.

Conclusion

We have no doubt that legislation can be crafted which would fully meet every goal President Clinton has set for health reform and produce a better employment-based system than we have today. We accept that this means private purchasers will have to comply with government-mandated changes in the way they operate. Nationally uniform rules are especially important to the effective operation of an employment-based system. We would be pleased to work with the Subcommittee and the Administration to craft nationally uniform rules that are acceptable to both multistate employers and the states. Thank you Mr. Chairman, I would be pleased to answer any questions you may have.

Mr. WAXMAN. Mr. Ray.

STATEMENT OF JAMES S. RAY

Mr. RAY. Thank you, Mr. Chairman. My name is James Ray. I greatly appreciate this opportunity to speak with you today on behalf of Bob Georgine, President of the Building and Construction Trades Department of the AFL-CIO.

Mr. Chairman, health care reform is of critical importance to the American worker. We appreciate your leadership and your commitment to an honest debate on health care reform. We are also grateful our Nation now has a President who has made health care reform a priority.

Over the years, we have been among the strongest supporters of a uniformed Federal scheme for the regulation of employee benefits plans, including health plans. This position is based on the nature of our labor-management multiemployer pension health and welfare plans established pursuant to the Taft-Hartley Act.

Among the proudest achievements of the building trades unions is that national system of multiemployer health and welfare plans that provide our members and their families with medical, hospitals, sickness, deaths, disability and related benefits. But for these multiemployer plans, few of our members would have health and welfare benefits coverage because of the mobile and seasonal employment patterns in the building construction industry and the small size of most construction industry employers.

For several decades now, our multiemployer health and welfare plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to our members as they move from one participating employer to another. In effect, all of the participating employers—scores, hundreds, and even thousands of participating employers—are treated as a single employer for purposes of providing health and welfare benefits coverage to members and their families.

Our multiemployer health and welfare plans are financed in reality by our members through their labor. The reality is that the employers' collectively bargained contributions are substitute wages for labor received. Instead of putting this money into the worker's paycheck, the employer pays it to the health and welfare plan to finance benefits coverage for the worker and his family.

The nature of collective bargaining in our industry is that the total compensation package cost is negotiated with employers, and the workers, through their union, decide how to allocate the total hourly cash wage between paycheck, pensions, health and welfare, apprenticeship and training and other beneficial programs.

An increase in the contribution rate for health and welfare coverage means less in wages or less in pension contributions or less in contributions to another benefits program. This process makes our members very sensitive to increases in the cost of health care coverage.

Over the years, the labor-management boards of trustees of our plans with professional assistance have designed health and welfare programs that balanced benefits needs and wants of the covered workers with the financing that can be provided by collectively bargained contributions. By pooling the contributions of many em-

ployers into a central fund, multiemployer health and welfare plans enjoy economies of scale in administration as well as enhanced purchasing power in dealing with health care providers and insurers. Multiemployer plans are the prototype health alliance.

Many multiemployer plans cover workers in multiple States. Some are national in coverage. Fortunately, because of Federal preemption under ERISA, our self-funded plans are not subject to State regulation. The cost and operation of these plans, if not their very existence, would be adversely affected if plans were subject to multiple, inconsistent regulation by the various States in addition to the Federal regulations imposed by ERISA, the tax code, and a variety of other Federal statutes. Every dollar spent by a multiemployer plan on regulatory compliance and administration is a worker's dollar, not an employer's dollar, and every dollar spent on regulatory compliance in administration by a multiemployer plan is a dollar that cannot be returned to the worker or his family in the form of health benefits.

One of the problems of the current health system is that our insured plans are subject to State regulation of their benefit design because of a loophole in ERISA preemption created by the U.S. Supreme Court in the *Metropolitan Life* v. *Massachusetts* case. This loophole enables States to mandate the benefits provided by insured employee health plans by requiring insurers to include certain benefits or services in all health insurance policies issued in the State.

Using this loophole, the States have enacted hundreds of different mandated benefit laws requiring insured plans to offer whatever benefits the State legislators want, or I should say whatever benefits provider group lobbyists want the legislators to mandate. These mandates have forced some of our plans to drop health benefits valued by our members in order to pay for State-mandated benefits.

This loophole has driven multiemployer plans to become self-funded to avoid State control over the benefits they provide and the costs they incur. Such State control interferes with the trustee's ability to balance the plan's benefits costs with the available financing.

Mr. Chairman, in the view of the time, I will skip over the problems that we have with the current system because they are detailed in Mr. Georgine's statement.

Let me conclude by saying, in short, our members are pleased with their health and welfare plans; plans which have been custom designed for them and which they control through collective bargaining and through the plans' boards of labor-management trustees. These mixed emotions about the current system translate into a strong feeling that comprehensive, national reform is needed immediately to deal with cost inflation and cost shifting.

We support President Clinton's reform proposal. We believe it goes a long way towards solving the problems confronting our members, our plans, and our employers. Of particular importance is that the President's proposal would enable our multiemployer plans to become health alliances and provide our members with enhanced benefits security.

Our multiemployer plan alliances would be regulated by a uniform Federal scheme enforced by the Labor Department rather than by the States. However, in conclusion, Mr. Chairman, we have not yet had an opportunity to fully analyze the President's revised proposal unveiled last week to ensure that the advantages it offers are not placed out of reach by operational impediments. In particular, we want to make sure that the Federal regulatory system for multiemployer plan alliances cannot be undermined by State action.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Ray.

[The prepared statement of Robert A. Georgine follows:]

TESTIMONY OF ROBERT A. GEORGINE, PRESIDENT
BUILDING & CONSTRUCTION TRADES DEPARTMENT, AFL-CIO

Mr. Chairman and Members of the Subcommittee:

My name is Robert A. Georgine. I have the honor of serving as President of the Building and Construction Trades Department of the AFL-CIO. I am pleased to appear before you today on behalf of the 15 national and international unions affiliated with the Department and the more than six million workers they represent to discuss health care system reform and, in particular, President Clinton's reform proposal.

<u>The Nature of Multiemployer Health & Welfare Plans</u>

Among the proudest achievements of our Unions is the system of multiemployer health and welfare plans that provide our members and their families with medical, hospital, sickness, death, disability, and related benefits.[1/] But for these multiemployer plans, few of our members would have health and welfare benefits coverage because of the mobile and seasonal employment patterns in the building and construction industry, and the small size of most construction industry employers.

A building tradesman may be employed by a particular employer for only a day, a week, a month or a few months to work on a specific project, and then move on to work on another employer's project, and thereafter another, etc. Between jobs, he or she might be off work for a day, a week, a month, or longer. A building tradesman might work for scores of different employers over his or her working life, with periods of unemployment between jobs. Most construction employers would not maintain their own employee health plans, particularly for transient workers.

1/ *A multiemployer health and welfare plan, often referred to as a "Taft-Hartley plan," is:*

- *a trust fund established through labor-management collective bargaining and pursuant to the Labor Management Relations ("Taft-Hartley") Act of 1947 by one or more labor unions and more than one employer of the union-represented workers;*
- *administered by a joint board of trustees with equal labor and management representation;*
- *providing medical, hospitalization, and other health-related benefits, as well as death, disability and sickness benefits, to covered workers and their dependents; and*
- *financed by employer contributions which are collectively-bargained between the sponsoring union(s) and the participating employers.*

These structural requirements are imposed by Section 302(c)(5) of the Taft-Hartley Act [29 U.S.C. §186(c)(5)]. Multiemployer health and welfare plans are also regulated by the Employee Retirement Income Security Act (ERISA) as employer welfare benefit plans.

For several decades now, our multiemployer health and welfare plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to members as they move from one participating employer to another. In effect, all of the participating employers -- scores, hundreds, and even thousands of employers -- are treated as a single employer for purposes of providing health and welfare benefits coverage to members and their families.

Our multiemployer health and welfare plans are financed, in reality, by our members through their labor. Our collective bargaining agreements typically require signatory employers to contribute to a particular health and welfare plan at a set dollars-and-cents rate for each hour worked by a covered worker. While the law considers these to be "employer contributions," the reality is that the employer's contributions are substitute wages for labor received. Instead of putting this money into the worker's paycheck, the employer pays it to the health and welfare plan to finance benefits coverage for the worker and his family.

The nature of collective bargaining in our industry is that the total compensation package cost is negotiated with the employers and the workers, through their Union, decide how to allocate the total hourly rate among cash wages, pensions, health and welfare, apprenticeship and training, and other beneficial programs. An increase in the contribution rate for the health and welfare plan means less in wages, or less in pension plan contributions, or less in contributions to another benefit plan. This process makes our members very sensitive to increases in the cost of health care coverage.

From the plan's perspective, financing depends upon the level of covered work, as well as the collectively-bargained contribution rate. That is, the plan generally receives employer contributions only for hours worked in employment covered by a collective bargaining agreement. If the level of covered work declines, plan income declines. The per hour contribution rate set by the collective bargaining agreements usually cannot be increased unless and until the labor-management parties negotiate a

new or modified agreement. A multiemployer plan cannot simply reach into the corporate treasury of an employer, in contrast to single-employer corporate plans.

Over the years, the labor-management boards of trustees of our plans, with professional assistance, have designed health and welfare programs that balance the benefit needs and wants of the covered workers with the financing that can be provided by the collectively-bargained contributions. To balance these factors, the trustees have developed various eligibility rules, benefit packages, and operational practices tailored to their particular circumstances. For example, plans have developed various systems for continuing coverage during gaps in employment and into retirement. These systems include "hours-bank" arrangements under which a worker's hours of covered employment are "banked" and used to pay for benefit eligibility during periods of unemployment. Other systems use eligibility periods during which a worker's covered employment builds credit towards benefit eligibility in a future period (e.g., covered employment in the first quarter earns the worker benefit eligibility for claims incurred in the second quarter).

By pooling the contributions of many employers into a central fund, multiemployer health and welfare plans enjoy economies of scale in administration as well as enhanced purchasing power in dealing with health care providers and insurers. Multiemployer plans are prototype health alliances. Many of our plans are self-funded. Many others insure some or all of their benefits with commercial carriers or other health insurers. Some of our plans have in-house administration, although most use professional third-party administrators who answer to the labor-management board of trustees.

Participating employers are advantaged in that they are required to do little other than submit their periodic contributions to the plan with verifying information. The employers need not become involved in plan administration or plan design. These functions are the responsibility of the plan's labor-management board of trustees and the professionals they hire.

Many multiemployer health and welfare plans cover workers in multiple States. Some multiemployer plans are national in coverage. Fortunately, because of

federal preemption under the Employee Retirement Income Security Act (ERISA), most of our multi-state plans are not subject to regulation by the States. The cost and operation of these plans, if not their very existence, would be adversely affected if the plans were subject to multiple, inconsistent regulation by the States in addition to Federal regulation. Every dollar spent by a plan on regulatory compliance and administration is a worker's dollar, and a dollar that cannot be returned to covered workers in the form of benefits.

Even intra-state multiemployer health and welfare plans would be adversely impacted if States, as well as the Federal government, could regulate them. This adverse impact is evidenced today by a loophole in ERISA preemption opened by the U.S. Supreme Court. This loophole allows States to mandate the benefit packages of insured employee health plans by requiring insurers to include certain benefits or services in all health insurance policies they issue, including policies sold to employee health plans. This loophole has driven many, if not most, multiemployer plans to become self-funded ("self-insured") and avoid State control over the benefits they provide and the costs they incur, inasmuch as such governmental control interferes with the trustees' ability to balance the plan's benefit costs with the available financing.

Problems With Current System

Our Unions are proud to have taken care of our own over the years, and to have dealt ourselves with problems that have arisen over the years.

But, the current crisis in the health care and insurance system is confronting our health and welfare plans, and our members, with forces beyond our control. And, these forces are endangering the very survival of our multiemployer plans and the benefit security of our members and their families.

Only action by the Federal government to comprehensively reform the current system can bring these forces under control.

Skyrocketing inflation in the cost of health care and insurance has cut severely into wages. We have had to shift increasing amounts of wages into health and welfare contributions to offset cost increases. In many cases, cash wages have been

frozen, with negotiated increases being redirected into the health and welfare plans to keep them afloat. In some areas, pension plan contribution rates have been reduced by the bargaining parties, with the savings being rechanneled to the health and welfare plans.

Many health and welfare plan boards of trustees have been compelled by cost pressures to cutback benefits, tighten eligibility rules, and increase out-of-pocket payments by covered workers. Our members no longer feel so secure about their coverage, particularly if they are unemployed for extended periods, as many have been during this long-running economic recession.

The effects of inflation in the cost of providing benefits have been exacerbated by the declines in contribution income to our plans caused by the recession. Fewer jobs to generate contributions means less income to our plans, even as benefit claims increase. Retirements induced by the unavailability of steady employment in some areas have increased the burden for those plans that provide coverage for retirees.

The recession in the building and construction industry itself is a product, in part, of health care cost inflation. As health care costs consume ever-increasing portions of government budgets and private sector resources, less money is available for investment in public and private building and construction projects. This means fewer jobs for our members, and less income for our health and welfare plans.

While we have struggled with these pressures to maintain responsible health coverage for our members, our non-union competition has gained an unfair competitive advantage. Non-union contractors have found a way to shift the cost of medical treatment for their employees and families onto the backs of our health and welfare plans and members; a way to cut their costs and increase ours.

The typical non-union contractor does not provide health insurance for its employees. If it provides any, it is inadequate coverage. This social irresponsibility gives the non-union contractor an immediate cost advantage over responsible union contractors which contribute to our multiemployer health and welfare plans.

This unfair competitive advantage is multiplied when the uninsured non-union worker or his family needs medical treatment. Lacking insurance coverage, they have no regular doctor, but rather go to hospital emergency rooms for treatment of minor and major ailments; the most expensive place to get treatment. And, when the worker is unable to pay for the treatment, the cost is passed onto our multiemployer health and welfare plans in the form of higher hospital bills, higher insurance premiums, and State uncompensated care assessments.

In other words, our members are being compelled by the current system to pay twice for health care: once for themselves and their families, and a second time for the non-union workers who take our jobs and their families.

In short, our members are generally pleased with their health and welfare plans; plans which have been custom designed for them and which they control through collective bargaining and through the plans' boards of labor-management trustees. But, health care cost inflation and cost-shifting beyond our control is undermining the plans and our members' standard of living, while placing them at an unfair competitive disadvantage.

These mixed emotions about the current system translate into a strong feeling that comprehensive, national reform is needed immediately to deal with cost inflation and cost-shifting, as well as with concerns about the quality of care, but that the reforms should enable us to retain what is good about our multiemployer health and welfare system so that our members will not be worse off under a restructured system.

<u>President Clinton's Proposal</u>

We support President Clinton's reform proposal. We believe that it goes a long way towards solving the problems confronting our members, our plans, and our employers, while preserving maximum flexibility for multiemployer health and welfare plans to continue to play a major role in the restructured health system for the benefit of our members. The following aspects of the proposal are particularly important to us.

* The proposal would require all employers to pay their fair share of the cost of health care for their employees. Non-union contractors

would no longer have a free-ride at the expense of our members and responsible employers.

* The proposal would put in place mechanisms for controlling health care cost inflation.

* The proposal would enable multiemployer health and welfare plans to form their own labor-management health alliances, either individually (if a plan meets the size criteria) or collectively, reflecting the fact that our plans have been operating as de facto health alliances for decades. In addition, the proposal would give a multiemployer plan the option of joining a government-sponsored Regional Health Alliance on behalf of its participating employers; that as an intermediary between the employers participating in the plan and the Regional Health Alliance. The basic health benefit package could be obtained through the Regional Health Alliance, with the multiemployer health and welfare plan providing supplemental health benefits and non-health benefits (e.g., disability, death, sick pay benefits) as they do now.

* The proposal would permit multiemployer health and welfare plans to continue to pay the full "premium" cost for benefit coverage, and would not require plans to impose deductibles, co-payments, or benefit limits. And, neither our members nor our participating employers would suffer adverse tax consequences as a result. This reflects the fact that our members already pay the full cost of benefit coverage by accepting a portion of their compensation package in the form of employer contributions to their health and

welfare plans; a characteristic that makes our members well aware of the cost of health care benefits to them.

* The proposal would permit multiemployer health and welfare plans to continue to provide supplemental health benefits not included in the basic benefit package without adverse tax consequences to our members or our participating employers for at least ten years.

* The proposal would extend government-financed health coverage to our retirees, and ease the financial pressure on active workers who currently subsidize the health coverage for retired members.

* The proposal would make a start towards reforming the fractured workers compensation system.

* The proposal would compel improvements in the quality of medical care by, among other ways, refocusing the system from treatment to preventive care and requiring greater accountability by providers of care.

These, of course, are broad strokes. And, the devil is in the details. We need to make sure that these advantages of the President's proposal are not placed out of reach by operational impediments.

We have not yet had an opportunity to fully review and analyze the revised version of the President's proposal that was unveiled last week. However, we understand that the details will be subject to discussion and further revision as affected groups are able to become familiar with the new proposal.

Several of our important technical concerns are explained in the attached paper which I offer as part of my submission to you. I ask you to include these concerns in your consideration of the proposal.

Thank you.

Mr. WAXMAN. Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI

Ms. IGNAGNI. Thank you, Mr. Chairman. I am Karen Ignagni, President and Chief Executive Officer of the Group Health Association of America, representing 347 health maintenance organizations with 32 million members, who account for about 75 percent of total HMO enrollment nationwide.

We are proud to note that HMO's already meet many of the objectives of national health care reform. They deliver comprehensive, high-quality health care at affordable, predictable costs. HMO membership has grown from 10 million a decade ago to approximately 42 million today. And HMO's clearly will play a major role in providing quality care at manageable cost under a universal health care system.

In addressing the States versus Federal regulatory responsibilities, we want to make it clear we certainly do not pretend to have all the answers. The measure by which GHAA examines this issue is whether, at the end of the process, we are assured of a level playing field for all entities providing health care coverage. We feel strongly that in order to guarantee a level playing field, there must be a uniformed set of standards for all health care delivery systems. We think it is in the interest of all concerned, especially consumers, to make sure that HMO's and other health plans are not operating under 50 set of rules.

Most proposals for reform emphasize, properly we think, the importance of assuring that only qualified health plans be allowed to market to consumers, whether through purchasing alliances or directly. We think it would be virtually impossible for consumers to accurately judge the qualifications of competing plans unless there are uniform national rules for certification and operation.

In addition, without such rules, it would be very difficult to develop the report cards that President Clinton has proposed because the data would be inconsistent from State to State.

Two adjoining States, for example, could have different criteria governing plan solvency, which is an important consumer protection issue. Start-up plans could be attracted to States with lenient requirements, which could potentially generate unfunded liabilities for established plans in those States and unfair risks for consumers.

In the absence of clear national standards, a supposedly universal system of health care protection could, in fact, provide widely varying levels of protection from State to State. Health care plans operating in many States, as many HMO's do now, could find themselves facing a maze of conflicting criteria.

These concerns are not conjectural. HMO's have been operating under a system of shared Federal-State regulatory authority for over 20 years. The 1973 HMO Act overrode certain restrictive State laws and established Federal quality criteria for HMO's, setting national standards for benefit packages and quality assurance procedures. Even with the HMO Act in place, however, there is considerable amount of State diversity in the operations and regulation over HMO's. Regulatory inconsistencies and unequal treatment of

competitors at the State level have created a myriad of problems for HMO's and other managed care organizations.

Mr. Chairman, our complete statement provides numerous examples. Let me just note here that in the area of regulatory inconsistency there is substantial variations in State requirements regarding benefits, quality assurance, utilization review, solvency and enrollee protection.

With regard to unequal treatment of competitors, some States have been slow to regulate the growing number of new managed care products which means established plans are operating under more stringent rules than newer competitors; a potentially major problem under national reform.

Finally, a number of State legislatures have enacted laws narrowly aimed at making it harder for managed care plans to compete with traditional fee-for-service arrangements. If such practices were to continue, the Nation could end up with 50 versions of health care reform.

Most State regulators, I believe, are as frustrated as we are with the status quo and would welcome the development of clear, uniform guidelines governing the administration, financing, operation, marketing and data collection practices of competing health plans. There are, in short, many reasons to support an approach to reform that spells out Federal and State responsibilities from the outset.

GHAA is in the process of developing recommended national practices for all managed care entities and we expect to have those recommendations available for you and your colleagues early next year.

The basic question at issue of what constitutes a health plan is simple to state but difficult to answer. Some State regulation is clearly necessary and desirable. But it seems equally clear that State regulators will be able to do a better and, above all, more consistent job if they are working within a consistent set of rules governing the entire health care marketplace.

Thank you very much.

Mr. WAXMAN. Thank you for your testimony.

[The prepared statement of Ms. Ignagni follows:]

Statement

of the

Group Health Association of America

Presented by

Karen Ignagni,

President and Chief Executive Officer

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to appear here today. I am Karen Ignagni, President and Chief Executive Officer of the Group Health Association of America. GHAA represents 347 health maintenance organizations with 32 million members who account for about 75 percent of total HMO enrollment.

We are grateful to you, Mr. Chairman, and to the other members of this Subcommittee who began advocating national health care reform years ago, and we applaud President Clinton for moving reform to center stage.

HMOs already meet many of the objectives of health care reform. They deliver comprehensive, high-quality health care at affordable, predictable cost — primarily by building on the strengths of the traditional doctor-patient relationship. HMOs rely on outstanding primary-care physicians who coordinate patient care to a degree that is virtually impossible under conventional insurance arrangements and fee-for-service medicine.

In addressing the subject of this hearing — state versus federal regulatory responsibilities in a reformed health care system — we want to state for the record that we certainly don't pretend to have all the answers. Because President Clinton's legislative proposal is just out and the debate is evolving, it would be imprudent, we believe, to try to delineate strict divisions between federal and state responsibilities at this time.

The measure by which GHAA examines this issue is whether, at the end of the process, we are assured of a level playing field for all entities providing health coverage. We feel strongly that in order to guarantee a level playing field there must be a uniform set of standards for all health delivery systems.

What, then, constitutes a level playing field? In the present context, we define it as one where barriers to fair competition are removed and where the ground rules are consistent nationwide. That raises the question of whether any game can be played under 50 sets of rules.

President Clinton proposes to level the playing field by making sure that all Americans have access to health care and are free to choose among

competing health plans. Without health care reform that establishes uniform standards, the field would continue to be overseen by 50 different referees. This, we submit, is cause for concern.

The states, charged with establishing a new system of health alliances to provide a mechanism for purchasing health care, understandably want maximum administrative flexibility. However, a rational marketplace requires regulatory consistency. Based on long experience, GHAA and its member plans believe that the nation needs a common set of national standards governing the certification of health plans, to assure that competitors are competing on the same basis of cost-effectiveness, service and quality in every state.

In our view, the states can and should function as laboratories of reform, encouraging the development of innovative approaches to health care. Nothing about that role, however, is inconsistent with the need for explicit federal guidelines. Indeed, measuring the efficacy of various state initiatives will be virtually impossible unless all states are working from the same baselines. That, in turn, is impossible under the present system.

The most obvious problem is that a supposedly universal system of health care protection could, in fact, provide widely varying levels of protection from state to state. Health care plans operating in many states, as many HMOs do now, could find themselves facing a plethora of inconsistent and sometimes conflicting criteria for certification and operation. Competing start-up plans, on the other hand, could be attracted to the states with the most lenient financial-management standards. Some plans operating on thin margins would risk insolvency, and the costs of such insolvencies would have to be borne, unfairly but inevitably, by HMOs and other plans that operate responsibly.

These concerns are not conjectural. HMOs have been operating under a system of shared federal/state regulatory authority for twenty years. The HMO Act of 1973 overrode certain restrictive state laws and established federal quality criteria for HMOs, covering, among other things, the HMO benefit package, quality assurance, and grievance procedures. Yet even with the HMO Act, there is a considerable amount of state diversity in the operation of HMOs. Regulatory inconsistencies and unequal

treatment of competitors at the state level have created myriad problems for HMOs and other managed-care organizations.

➊ **Regulatory inconsistencies:** Much of the frustration with state regulation stems from the sheer number of states and state agencies that become involved in issues of HMO structure, benefits, financing, and operation. The result is that with 50 statehouses and more than 100 state regulatory bodies involved in HMO oversight, nationwide standardization has been virtually impossible. Differences in state requirements that can create problems include:

▸ *Benefit mandates:* States require hundreds of state-specific mandated benefits which add to the overall cost of care while restricting HMOs' flexibility to structure benefit packages to meet the needs of particular groups. Moreover, the fact that different managed-care plans may be subject to different benefits requirements within the same state contributes to an unlevel playing field.

▸ *Quality assurance standards:* HMOs can be subject to a variety of duplicative, sometimes contradictory intra- and inter-state quality assurance standards. For example, an HMO that has both Medicare and Medicaid programs may have to go through three or more reviews of the plan's quality assurance program — with different criteria for each review. At the same time, other managed-care competitors may not be subject to state quality assurance requirements of any kind.

▸ *Utilization review oversight:* Twenty-five states have adopted comprehensive utilization review (UR) laws intended to regulate organizations engaged in managing care. Typically these laws require certification of UR agents and establish UR protocols. Although these laws are ordinarily designed to regulate free-standing UR firms, they may include HMOs within their scope. When they do, they tend to disrupt HMO operations, since HMOs have their own protocols and utilization review is an integral part of the HMO concept; it is also required under federal and state HMO acts.

▸ *Solvency requirements:* States have adopted widely varying capital and reserve requirements for HMOs. For example, some

states calculate deposit requirements using an expenditure-related formula; others use an income-related formula; others give the state insurance commissioner discretion to set the amount. Several states have adopted the formula recommended by the National Association of Insurance Commissioners in 1981 (and amended in 1988), but with their own variations. The net effect is that there are no uniform national solvency requirements. This could become a particularly vexing problem as new plans enter the marketplace in the wake of health care reform legislation.

▸ *Enrollee protection:* States have adopted a number of different approaches to protecting HMO enrollees against the failure of a plan. Some require HMOs to enter into insurance and/or reinsurance arrangements; some have adopted "hold harmless" clauses, requiring providers to look only to the HMO and not to enrollees for payment in the event of insolvency; and some require actuarial certification that an HMO's submitted enrollee subscription rates are sound. Again, the net effect of these inconsistent approaches is to create a patchwork rather than a system that guarantees the same level of enrollee protection everywhere.

❷ **Unequal treatment of competitors:** State regulators have generally been slow to regulate the growing number of new managed-care products being marketed, in part because state regulators typically focus on the entity being regulated rather than on the products offered by that entity. With health reform, there will be even more new entities entering the marketplace, offering managed care or similar arrangements. Inadequate regulation of competing managed-care products raises serious consumer-protection issues and can put existing HMOs and other managed-care organizations at a severe competitive disadvantage. For example:

▸ *HMO vs. PPO regulation:* Forty-seven states have legislation providing for regulation of HMOs; only about half as many states regulate preferred provider organizations (PPOs), and regulatory supervision of PPOs is much less intense.

Yet while HMOs are integrated delivery systems with built-in quality assurance programs, PPOs typically are not even organizations as such, and may not offer quality assurance mechanisms and other essential managed care functions. In fact the sole

purpose of a PPO may be to offer a discount fee rate. In the absence of regulation, PPO operating costs can be kept artificially low. HMOs, on the other hand, cannot skimp on the essential elements that constitute an integrated delivery system.

▸ *'Any willing provider' legislation:* GHAA estimates that 25 states have adopted laws that can be interpreted as requiring HMOs to deal with any provider who is willing to accept the HMO's basic terms and conditions of participation. Proponents claim that these laws simply uphold basic fair-trade principles, when in fact they undermine a concept basic to the viability of HMOs: their right to control quality and manage costs by establishing closed panels.

In addition to being disruptive, "any willing provider" laws are also usually ambiguous and difficult to implement. For instance, several states have adopted "open pharmacy" requirements allowing non-participating pharmacies to serve HMO enrollees as long as the pharmacy is willing to meet the HMO's terms and conditions. Aside from demonstrating a lack of understanding of how and why closed panels are used to achieve economies — in this case by buying drugs in volume at discount — the requirement is unenforceable, since it assumes that a pharmacist can unilaterally accept an HMO's terms without participating in the HMO's credentialing process and, further, that the pharmacy has already met the HMO's terms when the enrollee walks in.

Mr. Chairman, these examples underscore the importance of enacting national health care reform legislation that establishes a truly level playing field at the outset rather than attempting to do so later, after problems both old and new have piled up around the country. Our experience suggests that playing catch-up ball is expensive, frustrating, and not in the interest of either consumers or providers.

Nor, I would add, is it in the interest of state regulators. In our experience with the National Association of Insurance Commissioners, the National Association of Managed Care Regulators, and most individual state regulators, we have generally found them to be as frustrated as we are with the status quo. NAIC, for example, has developed model legislation incorporating excellent solvency and capitalization requirements, but has no authority to compel adoption of such requirements. I believe

that most regulators welcome the development of clear, uniform national standards governing the administration, financing, operation, marketing, and data collection practices of competing health plans.

We are particularly concerned that if the present bifurcated regulatory system is perpetuated, the playing field could tilt even more — to the detriment of HMOs and to the advantage of new entries marketing themselves as managed-care plans. Recently, White House health policy adviser Ira Magaziner suggested that doctors and hospitals should have access to special low-interest loans to help them compete with large HMOs and other managed-care plans. This proposal could lead to unintended inequities if pools of capital are, in effect, earmarked for such loans. In the absence of a coordinated nationwide policy, some states would be under great pressure to make low-interest health care investment capital available primarily or even exclusively to constituents with the most influence in the state legislature — an outcome clearly at odds with what Mr. Magaziner has in mind.

There are, in short, many reasons to support an approach to reform that spells out federal and state responsibilities from the outset. GHAA is in the process of developing recommended national practices for all managed-care entities in many of these areas. As you can appreciate, the process of achieving consensus on these kinds of standards is both complicated and enhanced by the diversity within the industry. However, we expect to have many of these recommendations available early in 1994.

As HMOs and similar managed-care organizations assume a more central role in the nation's health care delivery system, the role of state regulators becomes more crucial. The basic question at issue is simple to state — *who can be a health plan?* — but difficult to answer. There is a delicate balance between too much regulation, which impedes HMO development and operation, and too little regulation, which may endanger consumers. Some state regulation of HMOs is clearly necessary and desirable. But it seems equally clear that state regulators will be able to do a better and above all a more consistent job if they are working within a consistent set of federal rules governing the entire health care marketplace.

Thank you.

Mr. WAXMAN. As you might have noticed, we are being summoned to the House Floor for a vote, so I will take a break just to respond to that vote and we will come right back and hear from Ms. Fox and then ask some questions. So we will have a short recess.

[Brief recess.]

Mr. WAXMAN. The meeting will come back to order.

Ms. Fox, we are looking forward to your testimony.

STATEMENT OF ALISSA FOX

Ms. FOX. Thank you, Mr. Chairman. I am Alissa Fox, the Executive Director for Congressional Relations with Blue Cross/Blue Shield Association.

Blue Cross/Blue Shield plans provide coverage to 678 million people. Over a third of our enrollment is in managed care networks. The Blue Cross/Blue Shield Association strongly supports the President's objectives for health care reform, health care coverage for everyone, strict new standards for insurers, and cost containment through managed care networks. We believe the best way to achieve these goals is through a strong Federal and State partnership.

The Federal Government should set the standards and States should be responsible for overseeing the system the way that makes most sense for them. States have been taking a leadership role in enacting laws to extend health care coverage and control costs. Many States have put new rules in place requiring insurers for the first time to abide by specific standards in providing coverage to small businesses, and several States have enacted broader reforms. These reforms, while a promising first step, vary considerably State by State, and we have learned that States cannot achieve health care reform without leadership by the Federal Government.

Fifty separate health care plans with 50 different standards will not work. However, States provide the flexibility that is needed to meet local needs with local solutions. After all, health care delivery is and should continue to be local. But this local flexibility must occur within a consistent framework of strong Federal guidelines.

We believe Federal standards are needed in three major areas: Insurance reform, cost containment, and universal coverage. We believe strict Federal standards for insurers is the first and most important step. These standards must be the same in all States. States should be responsible for applying and enforcing these standards and certifying that health plans abide by these standards. All health plans must meet these standards, including self-funded plans.

States will need flexibility in making sure that the specific standards respond to local conditions. For example, the specific standards that are appropriate to ensure access in a rural State are likely to differ from those that are appropriate in highly urbanized States.

Federal standards are critical to achieve cost containment. Federal standards are needed to define standard benefit packages, to define standardized data, on quality of care, and, of course, the Federal Government is needed to make the tax code changes we be-

lieve are important to promote cost conscious decision-making in the purchase of health care services.

As for the goal of universal coverage, this can only be achieved by Federal legislation, and we believe the best way to achieve universal coverage is by building on the existing employer-based system and creating competitive markets to both control costs and ensure responsiveness to consumer needs.

We do not believe that mandatory health alliances of any size are needed to achieve the goals of universal coverage and cost containment. Essentially, all of the functions that the President's proposal assigns to health alliances could be performed by States through their departments of insurance or departments of health. In fact, alliances will increase administrative costs by duplicating many functions now performed by States, employers and health plans. We believe hinging success of reform on creation of these new entities may be a very risky strategy.

Mr. Chairman, I would add that today you heard that alliances are needed to pool purchasing power. We believe if you look at the Clinton plan that the pooling really takes place by requiring health plans to charge the same community rate to all their subscribers. We do not think that you need an alliance to accomplish pooling because actually community rating is the place that the pooling occurs.

Thank you, Mr. Chairman. We look forward to working with you and this committee so that health care reform can become a reality next year.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mary Nell Lehnhard follows:]

STATEMENT OF BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify on the important issues of the role of the states in health care reform.

While such reform has moved to the top of the nation's domestic policy agenda, health care, like politics, will continue to be local. In order for reform to be responsive to local needs, the states should play a vital role in changing our health care system.

The states have been the laboratories for health care reform. Twenty-eight states have enacted laws to reform the small group insurance market. Several states, beginning with Hawaii, have enacted broader reforms. We have learned a great deal from these state efforts.

We have learned that the states cannot achieve the goals of reform -- universal coverage and control of costs -- by themselves. Fifty separate health care reform efforts, creating 50 different sets of standards, will not work. States provide, however, the flexibility that is needed to meet local needs with local solutions that operate within a consistent framework of strong federal guidelines. Successful reform will require a strong, working partnership between federal and state governments, just as it will require a strong, working partnership between the public and private sectors.

Federal Standards and Guidelines

The federal government must establish the framework for national health care reform. Federal standards are needed in three areas: insurance reform, cost containment, and universal coverage. In addition, the federal government can support implementation of reform through the adoption of standards for administrative simplification, research into better methods for measuring health care outcomes and quality of care, assessment of new technologies, and the development and dissemination of practice guidelines to promote more cost-effective clinical practice.

Federal Standards for Insurance Reform. We believe strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market -- and assuring fairness to consumers. New standards for health insurers both would assure the availability of insurance and bring about real price competition for the first time in the financing and delivery of health care. These standards must be the same in all states. Federal standards defining an Accountable Health Plan should:

1. Require insurers to accept everyone regardless of their health status or employment;

2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;

3. Prohibit insurers from dropping people or groups when someone gets sick, and require insurers to offer continued coverage when a person loses his or her job,

4. Require insurers to set premiums fairly and not penalize people who are sick or older; and,

5. Require insurers to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and conformity to standards.

These same strict standards must apply to more than insurers and Health Maintenance Organizations. Self-funded plans must play by the same rules and be held to the same standards as Accountable Health Plans. These federal standards will require all health plans to compete fairly.

<u>Cost Containment Standards.</u> Federal standards also are needed to allow individuals, employers and employees to weigh both price and quality when purchasing coverage. These federal standards should:

1. Standardize health benefit designs. A limited number of standardized benefit designs will allow consumers to easily compare products, although we do not believe a single standardized benefit design will be workable. These benefit packages should be the same in all states, and should be the same for large and small employers, as well as individuals and families who do not purchase coverage through an employer.

2. Provide consumers with standardized data on quality of care and subscriber satisfaction. Standardized measures of quality and subscriber satisfaction will enable consumers to select a health plan based on both cost and quality. To hold administrative costs to a minimum and enable more meaningful

comparisons, the federal government should develop standard measures that can be adopted by the states.

3. Limit to an amount consistent with cost-efficient health plans the federal tax deductibility for employers, and the tax exemption for employees, of employer contributions for health benefits. Changes in the tax treatment of employer contributions for health benefits will strengthen the incentives for employers, employees and individuals to weigh price more carefully when selecting a health plan. As price becomes more important to consumers, health plans will make greater efforts to find more effective ways of managing costs.

These federal rules would encourage the expansion of organized delivery systems that have a proven ability to change inefficient and ineffective utilization patterns and cause providers to become more efficient providers of health care.

<u>Universal Coverage Standards.</u> Insurance reform would reduce the number of people without insurance benefits, but it would not lead to universal coverage. A requirement for employers to offer and contribute to the cost of health benefits, and for individuals to accept and pay for the balance of the premium, would be necessary to achieve universal coverage.

Because such a requirement would impose a severe burden on many small employers, subsidies would be needed. These subsidies should be targeted to companies that rely heavily on low-wage workers and must be defined by the federal government.

The Role of the States

The federal standards will define the rules under which health plans can and will compete. The states should be responsible for applying and enforcing these new rules. The state responsibilities should include: certification of health plans; enforcement of market conduct standards; financial regulation of health plans; dissemination of consumer information; and risk adjustment. In some areas, states may need greater flexibility than in others.

Certification of Health Plans. One of the primary responsibilities of the state will be to certify the health plans that meet the standards for accountability. These standards include compliance with the insurance reforms described above, but also include certification of the capacity of the health plan to meet the medical needs of current and future members, provide access to services throughout the health plan's service area, and meet certain quality standards.

States should have some flexibility in defining standards for accessibility and quality of care, and for methods of assuring compliance with quality and access standards. For example, the specific standards that are appropriate to assure access in a rural state are likely to differ from those that are appropriate in highly urbanized states. Similarly, states should have responsibility for defining medically underserved populations and developing strategies to make sure that the needs of these populations are met.

Enforcement of Market Rules. In addition to establishing the rules for a newly competitive market, states will need to monitor and enforce compliance with those rules. There should be no deviation from the strict federal standards requiring all

health plans to accept everyone seeking coverage regardless of health status and providing portability of benefits when a person changes health plans. However, the implementation of these new standards may proceed more quickly in states that have already adopted reforms in, for example, the small group market.

Financial Regulation. States have been responsible for the financial regulation of insurers for many years. These responsibilities will continue. States will need to assure their citizens that the health plans operating in the state are financially sound.

In addition, states will need to enforce the requirement that all consumers be charged a fair price for coverage. The states will need to review and approve the rates that are proposed by the health plans to make sure that the health plans are complying with the federal standards for community rating and that the health plans are able to sustain their operations at the proposed prices. The specific criteria used by states to evaluate and approve rates may vary depending on established patterns of utilization, the degree to which health plans and subscribers have already adopted effective managed care techniques, and the number and type of health plans remaining in the market after reform.

Consumer Information. The federal government can help to define standard measures for quality and consumer satisfaction, but the states should have primary responsibility for assembling this information and making it available to consumers. States also may need the flexibility to develop their own measures of cost and quality that respond to local needs.

Risk Adjustment. Risk adjustment involves the transfer of funds among health plans so that those selected by higher numbers of older persons or persons in poor health are able to compete fairly. The state will have a significant responsibility for defining the methods to be used to measure and adjust for risk, and for supporting the transfer of funds among health plans. States will need substantial flexibility in this area, although the federal government may have a role in providing technical assistance. For example, each state may need to develop its own methods to correct for differences in the demographic composition of each health plan's enrollment. Similarly, states that choose to adopt forms of pooling for high risk medical conditions will need to tailor the list of conditions that are used to reflect local disease patterns. A uniform federal approach is not likely to be responsive to local conditions.

Purchasing Alliances

We do not believe that large, mandatory health alliances of any size are needed to achieve the goals of universal coverage and cost containment. Essentially all of the functions that the President's proposal assigns to health alliances could be performed by states through their departments of insurance or departments of health. States should, however, have flexibility in designing and implementing other methods of achieving the goals of reducing administrative costs and expanding the ability of individuals to choose their own health plans, e.g., by gaining experience with individual choice through voluntary alliances.

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Single Payer Option

While the states will need substantial flexibility, the strategies they adopt should be consistent with the basic federal strategy outlined in the President's recent legislative proposal. This strategy relies on the creation of competitive markets to both control costs and ensure responsiveness to consumer needs. Allowing states to adopt a "single payer" reform under which all state residents receive benefits under a single, public sector health care program, would be moving in a direction that is inconsistent with this federal strategy.

In summary, the federal government should have the principal responsibility for setting the standards for a reformed market that creates true price competition for the first time. These federal standards include:

- insurance reform standards;
- cost containment standards; and,
- universal coverage standards.

States should have principal responsibility for applying and enforcing these federal standards. They will need flexibility in making sure that the specific standards and methods of enforcement respond to local conditions. Areas in which state flexibility are particularly important include:

- assuring access to services;
- developing quality standards for accountable health plans;
- approving rates proposed by health plans;

- developing information to help consumers select a plan based on both cost and quality; and,
- developing specific methods of adjusting health plan premiums for differences in risk.

We believe that successful reform relying on a partnership between the federal and state government can:

- Assure every American has coverage by asking employers to contribute to a basic set of benefits and providing subsidies for low-income people.
- Control costs by eliminating the ability of insurers to compete based on avoiding people with a medical problem -- insurers must accept everyone and compete based on managing costs; standardizing benefits and publishing consumer satisfaction and health outcomes so consumers can compare value; and making employers and individuals more cost conscious by limiting the amount of coverage that is tax free to the cost of a cost-effective plan.
- Assure fair treatment of consumers through strict federal standards for insurance reform.

Mr. WAXMAN. Mr. Brown, do you have——

Mr. BROWN. Why don't you begin.

Mr. WAXMAN. I am going to have to leave. Do you want to take over and ask a few questions now?

I want to thank the four of you very much for your testimony. Members may have questions to ask of you in writing for the record, and I would appreciate it if you would respond in writing.

Mr. RAY. Happy to, Mr. Chairman.

Mr. BROWN [presiding]. Mr. Peres, you argued in your testimony, and I had the written copy, I am sorry I was not here earlier when you testified, that multistate employers will not be able to offer their employees the same network-based health coverage if States opt for single payer. What does that mean? Explain that to me a bit, if you would.

Mr. PERES. Currently, multistate employers typically offer the same benefits to their employees regardless of where they are. In our case, we are located primarily in five States. We have some employees here in the District and some other locations, and we have one benefit plan, depending upon where people live, some of them, for example, have a point-of-service, managed care plan, otherwise known as an open-ended HMO. Others have a PPO plan where the point-of-service plan is not yet available.

If you go to a single payer State, or a State goes to a single payer system, what happens then is we do not have the flexibility to put in our, to maintain those benefits for our employees. We have to provide whatever the State said in that location.

The other complicating factor for us—there are two complicating factors. One is, as a corporate alliance, if that State was a big enough State for us, we could fall beyond, or below, rather, the threshold and have to give up being a corporate alliance and go into a regional alliance.

I think another major concern, a concern of every multistate employer is the crossing of the State boundaries where people live in one State, work in another State, seek health care in a third State. We have employees who work in one State, live in another State, may have dependents in two other States going to college or perhaps because of a divorce or whatever, and all of these things add to the complications. Our concern would be conflicting rules, conflicting regulations.

And if I can just throw in one illustration to explain what could occur. I lived for 13 years in Canada, I was a hospital administrator there, and came across somebody who had a heart attack while traveling overseas, ran up a bill that was then the equivalent of about $10,000, paid the bill, came back, submitted it to their provincial health plan. Between the time they paid the bill and the time that the bill was submitted, the currency of the country where they were was devalued by 50 percent.

The provincial health plan said, oh, we are not only to pay you the $10,000, we are going to pay you in the local currency that you had to pay in. So they not only got only 50 percent, but I think the currency was devalued again by the time that they were reimbursed, so they lost out again.

Now, our concern would be if we live in one State—if somebody lives in one State, is covered under one State, goes to another

State, there is nothing to say at what level things need to be paid. If you cross the State boundaries, if there is a difference between what is paid and what is charged, who picks it up?

These are those kinds of issues that are very real issues that we live with every day that either need to be anticipated or you will be facing, your constituents will be facing, as we go forward.

We can fix them in our benefit plans very easily. It is a lot less easy to fix when they are in legislation or regulation.

Mr. BROWN. You argue that it would be difficult for multistate employers to transfer employees into those States that have single-payer because the public is skeptical about Government's ability to run a health care system that way.

Why do you think single-payer—why do you think single-payer can't be attractive enough to the health care buyer, if you will. Understanding your dislike of a system like that, why do you think it can't be built to make it as attractive—I mean, the requirements under the Clinton plan or the quality must be as good, the services must be as good, it must meet the same criteria, or the health alliances or the large companies that opt out must meet and you can certainly argue that the choice is more wide ranging.

Mr. PERES. It may be that there will be no difference, but it is the employee's perception of the difference. And it is just one more difference that employee—an employee needs to take into—one more issue that the employee may take into account when asked to move for a new job. The same they will look at housing costs, they look at education, they look at cost of living, they look at a whole variety of factors. On a personal level, they may say I like what I have, I don't know what I will be getting, and they may say I don't want to move.

And that may be one reason—I am not saying it will be the only reason, but it may be—it will be a reason, a factor that people many take into account.

Mr. BROWN. With all due respect, I am not sure it goes much beyond people's human nature. Natural resistance to change in something as key to their lives as health care.

Let me ask, this is really for any of the four of you, in the alliance, several companies in this country now, hundreds if maybe thousands of companies are providing for employees pretty good wellness programs, anything from anti-smoking campaigns to fitness centers to encouraging bringing physicians on premises occasionally for various kinds of blood pressure checks and all that, bringing nurses in, doing all kinds of things, encouraging women to get mammograms, encouraging women to do prenatal care, get their children immunized, all of that. That is reflected in some cases or perhaps in most cases in insurance premiums for those companies.

What is the recommendation of any of you to build some of that—some of those incentives into the health alliances, those companies that are less than 5,000 that enter the alliances, when 10 percent of the companies in the alliance may do that, most of the companies in the alliance won't. How do you give those 10 percent some incentive to continue those programs, addressed to any of the four of you?

Ms. IGNANI. I will take a crack at that. I think from the standpoint of our plans, they have put quite a premium on the emphasis on prevention and preventive services. The question I guess in the end is whether or not you want the plans to be leading the way or employers or some combination of both.

For our plans, we actually go out and encourage people to come in for flu shots if they are over 65. In many plans, they are providing transportation with senior volunteers for people to do that. We have very active programs in the area of prenatal care, postpartum care. We regularly remind women it is time for a mammogram on a particular schedule. Plans all over the country are doing that and increasingly getting into hypertension screening and a number of other things that you mentioned.

I think that that is what distinguishes our plans from the fee-for-service sector and we want to think about that as a society as we move forward with, I think, the objective we all share, which is to improve the public health as opposed to simply setting up a situation or a system that treats people when they are sick.

Mr. BROWN. Anyone else care to comment on that?

Mr. PERES. If you want the services to be delivered, it is not enough just to say you have to provide them because what we find in many cases although you may offer the benefit, you may be willing to pay for the benefit, people may not seek it out or the plans that have agreed may not be actively offering it.

There is an organization that is supported very strongly by a lot of large employers called the National Committee for Quality Assurance and they have taken over something called the health employee—Health Plan Employer Data Set—HPEDS—which was created jointly by a number of health plans, some of Karen's members, and a number of employers to look at plan performance. And some of the things specifically that they look at are those very issues.

It is not just are these benefits being provided, but how many women do get mammograms, what are the Caesarian section rates, what are the immunization rates? I think it is only through those kinds of measures that you can really hold the plans up and say, you know, you have to do better. You are not doing as well as others in your area. It is not just—it is not just the importance of offering it, it is the importance of delivering it.

Mr. BROWN. Let me conclude with just a couple more questions back to single-payer for a moment, if you would.

Did the President's plan go too far in encouraging—first of all, did the President's plan go too far in encouraging single-payer in taking down some of the barriers, if you will, as the first, as Mr. Vladeck said earlier, or one of the two people with him said, and second, were there disincentives that they took out that are particularly objectionable to you that you thought that should not have been addressed that way?

Any of you familiar enough with this sort of the structure of that to answer that?

Ms. FOX. No, but I would just add that we don't believe that States should have the option of going to single-payer. We don't think that is in—that is consistent with his goal of creating competitive environments. We don't think it is good for the country, basically, so I just want to comment on that.

Mr. BROWN. OK.

Mr. Ray.

Mr. RAY. I would also join. I don't want to be critical of the President's proposal at all. As I indicated in my testimony, we are generally supportive. One of the areas of concern that we do have relates to the role of the States in the system.

As I indicate in our prepared testimony, we are strong supporters of a uniform system, for many of the same reasons that you have heard from my fellow panelists here a few moments ago. We have national plans, regional plans that cover multiple States, we have workers who move from State to State.

Very frequently, in the construction industry, workers are very mobile from State to State, especially on projects like pipeline projects. And we can't have a situation where we have different benefits coverage in different States, especially since our health care is really an aspect of our workers compensation.

As I indicate in my testimony, employer's contribution is employer's contribution only for legal purposes. The reality is every dollar contributed to our plans is a worker's dollar, it is a dollar that is not in his paycheck. So if you have different systems from State to State, you are going to have different cost mixes that affect our collective bargaining.

I would also say that we have had some bad experiences with our insured plans that are subject to State regulation under current law because of a loophole in ERISA created by the Supreme Court that allows the States to mandate what benefits are included in all employee health plans that are insured.

And we have had lots of bad experiences where State legislatures are dictating what our benefit package is going to look like, not because of what our members want, but because what lobbyists have persuaded State legislators they ought to mandate and we can't live with a system like that.

Mr. BROWN. In spite of the fears of you, Mr. Ray, and you, Ms. Fox, of giving the States the option of doing single-payer, I just can't believe, understanding all politics is local, the old saw, that States at all will choose at least single-payer. I don't see that the political atmosphere of very many State capitals would frankly allow that.

That being said, whether or not you agree with that statement, that being said, do you fear the size of the health alliances in sort of following up on a question a couple of panels ago, if you were here, the size of the health alliances and if they continue to get a little bit larger and continue to merge over time that the almost natural evolution might be single-payer in States.

Is that a fear you have more than initially setting up single-payer? Do you think of it that way?

Ms. FOX. We don't think mandatory health alliances of any size is necessary or desirable at all. In fact, when we look at what the goals the President has said that he wants to achieve with the alliances, for example pooling of risks, we don't think that the alliance even accomplishes that. It is really insurance reform requiring health plans to charge the same, their best rate, and offer the best same rate to all customers.

We think that is where the pooling occurs under the President's plan, that you don't need alliances to accomplish pooling of risks. So we don't think you need those alliances at all and, yes, we do think it does create the infrastructure for a single-payer program.

Ms. IGNANI. Mr. Brown, I would say that our plans are—no one really knows what alliances mean and it is a new proposition that has been introduced. We are still at the point where we are evaluating the implications of all that has been proposed and, admittedly, it is going to take a little while to ascertain the impacts.

However, what our plans have observed is that because this is a new proposal, there are many elements associated with it, there are many things we don't know in terms of how they should be best constituted, how organized, what they should do, what the relationship will be with State governments, with purchasers, with plans, et cetera, our recommendations would be to begin the alliances in the pooling mechanisms where it is needed, immediately, which seems fairly clear-cut to us in the small employer market, and then establish them, see how they work, and make some decisions down the road about whether they should be expanded.

Mr. BROWN. Mr. Peres?

Mr. PERES. Yes, I think that the ADPP-ADWP membership is concerned about the size of alliances because of, number one, the position it places us in, but also the alliances are given a number of different roles, there are a purchasing organization. To some extent, they carry out some regulatory functions. They are a fiduciary organization and they are an administration organization.

If you think about Congressman Hastert's comments earlier about one regional alliance for the Chicago metropolitan area, you know, you are probably talking about an alliance that covers upwards of 4 million people. If any of you—if any of the people in this room have gone through trying to do an open enrollment with the plan as it currently states, there is one open enrollment period for everybody in a regional alliance area, one open enrollment period once per year.

You are talking about a new organization being set up expected to do an open enrollment for about 4 million people. And, you know, they probably have to start in February or March for the following January. I mean, we are going through that now and you know, just with the people that we have and we have been doing it for a long time, you know, it takes an awful lot of work, an awful lot of time to sort through these issues.

I think from the administrative perspective, the administrative challenges they will have, that the size that they are anticipated to be is just way too large.

Mr. BROWN. OK. I thank all of you for your testimony.

The subcommittee is adjourned. Thank you.

[Whereupon, at 2:35 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The following articles were previously submitted by Hon. Alex McMillan in connection with his opening statement before the joint hearing of the Subcommittee on Health and the Environment and the Subcommittee on Commerce, Consumer Protection, and Competitiveness on November 2, 1993. (Health Care Reform—Part 3, Serial No. 103-75):]

[From the Washington Post, Nov. 2, 1993]

First Lady Lambastes Health Insurers

METHODS HAVE 'BROUGHT US TO THE BRINK OF BANKRUPTCY,' CLINTON SAYS

[By Dana Priest]

Hillary Rodham Clinton yesterday lashed out at the health insurance industry, calling it an industry that "has brought us to the brink of bankruptcy because of the way that they have financed health care."

"It is time for . . . every American to stand up and say to the insurance industry, 'Enough is enough. We want our health care system back,'" she said.

In an address to the American Academy of Pediatrics, Clinton singled out television ads funded by the Health Insurance Association of America, a trade group of mainly medium-sized firms that has exchanged barbs with the White House for several months.

"They like what is happening today," she said. "They like being able to exclude people from coverage because the more they can exclude, the more money they can make. It is time that we stood up and said "We are tired of insurance companies running our health care system.'"

White House officials said the attack was the beginning of a strategy to respond aggressively to opponents and recapture the rhetorical offensive. The White House was put on the defensive when its final version of the health plan was delayed by several weeks and detractors jumped into the void.

Insurance association officials said they were surprised at the criticism. "I think the polarization is very unhealthy," said Charles N. Kahn III, executive vice president of the group.

Kahn said the ads, which feature a husband and wife at the kitchen table worrying over the how the president's plan will affect them, were based on the preliminary draft of President Clinton's plan. He said the ads probably pushed the White House to make changes in its final version, reducing the role of the Federal Government in setting prices and dictating which companies can sell health policies.

"We'd like some credit for it, rather than to be hit on the head," Kahn said.

"What you're seeing here is a mini-campaign on health care," said one White House official, "and just like a campaign, you can't let the charges go unanswered."

Both in tone and as a sales strategy, Hillary Clinton's remarks differed from the sort of generally positive, "we-are-willing-to-work-it-out" speeches she and the president made in the days immediately before and after the official presentation of the health care reform bill to Congress last Wednesday.

But the insurance association and White House surrogates have been sparring publicly for many months. When the association launched a television spot saying "the government may force us to pick from a few health care plans designed by government bureaucrats," the Democratic National Committee responded with an ad saying the plan was designed for the American people, not for insurers.

The association represents 270 medium- and small-sized insurers, many of whom could be put out of business by reform. It is in the middle of a $5.5 million media campaign on reform and is undertaking a "grass-roots" challenge to the Clinton proposal that includes targeting key Members of Congress.

The insurance group supports the administration's proposal to have employers pay the major share of their workers' coverage, but it opposes many other basic elements, such as the establishment of large health care purchasing cooperatives—health alliances—and limits on insurance premiums.

In her speech to the pediatrics group yesterday, Hillary Clinton decried a system under which 20 percent of children did not visit a doctor in 1992, 50 percent of inner-city children have not been immunized against preventable diseases and 9 million children are uninsured.

"They are the children of the waiters and waitresses of restaurants that serve you," she said. "They are the children of the chambermaids and maids in motels and hotels where you stay. They are the children of men and women who go to work at 5 in the morning in small factories . . . They are the children of working parents . . . and it is a disgrace that we should begin to stop right now."

The White House health reform plan would include a wide array of preventive services for children in its basic benefits package. The academy has endorsed many elements of the bill, but wants a greater number of free preventive doctor visits than are included in the plan.

[From the New York Times, Nov. 2, 1993]

Hillary Clinton Accuses Insurers of Lying About Health Proposal

SAYS INDUSTRY ADS MISLEAD PUBLIC TO GUARD PROFITS

[By Adam Clymer]

Washington, Nov. 1—Hillary Rodham Clinton today accused the health insurance industry of greed that has driven the Nation "to the brink of bankruptcy" and of lying to the public about the President's plan in order to protect its profits.

The First Lady denounced television advertisements run by the Health Insurance Association of America against the administration's health care plan. She said that its message that the plan "limits choice," a theme of one of the industry's advertisements, was false. She said insurance companies "like being able to exclude people from coverage because the more they can exclude, the more money they can make."

'WILL BRING CHAOS'

Mrs. Clinton goes out of her way at almost every stop to emphasize the administration's willingness to negotiate, and did so again today. But on rare occasions this year she has shown an angrier and less compromising side, making scathing attacks on groups like the drug industry and, today, the insurance industry, that she says block progress.

Charles N. Kahn 3d, executive vice president of the insurance association, the trade group for more than 300 health insurance companies, defended the advertisements in a statement. It said, "The accuracy of H.I.A.A.'s advertisements cannot be questioned, after all, they are based entirely upon the Clinton health care reform proposal as made public."

Mr. Kahn said that the association supported the administration's goal of universal health care coverage, but that the group believed that various price limitations including limits on how fast insurance premiums could go up, "will bring chaos to the system."

Mrs. Clinton, in a speech delivered in measured but angry tones to a friendly audience at the American Academy of Pediatrics, complained of the insurance group's $6.5 million advertising campaign. "They have the gall to run TV ads that there is a better way, the very industry that has brought us to the brink of bankruptcy because of the way that they have financed health care," she said.

Mrs. Clinton added: "One of the great lies that is currently afoot in the country is that the President's plan will limit choice. To the contrary, the President's plan enhances choice."

'GOVERNMENT BUREAUCRATS'

She said the insurance industry was now limiting choice, as patients found every year that their employers' health plans restricted them to smaller lists of approved doctors and fewer hospitals.

The administration proposal provides that in most States everyone would be offered the choice of at least three health care plans, including one of traditional fee-for-service plans will no restrictions on choice of doctor—although usually with somewhat higher costs than other approaches, like a health maintenance organization.

Critics contend that people could be forced into plans they do not prefer if their first choices fill up. The administration says that now most people's choice is limited to what their employers choose to offer them.

And then she brought up the television advertisements, "the kind of homey kitchen where you've got the couple sitting there talking about how the President's plan is going to take away choice."

In the first of the association's two television advertisements, there is a couple seated at a kitchen table reminiscing fondly about an old health insurance plan, and worrying about whether a new plan would cover them as well. An announcer says, "The Government may force us to pick from a few health plans designed by Government bureaucrats." And the woman says, "Having choices we don't like is no choice at all."

In a second television advertisement that the group is now running, the same couple is shown agreeing that it is necessary to do something about health care. But they complain about the details of the Clinton plan, and the woman says, "The Government caps how much the country can spend on all health care and says, 'That's it!'"

The man asks, "So what if our health plan runs out of money?" the woman shrugs and says, "There has got to be a better way."

The Clinton proposal provides that a health alliance may borrow, on a short-term basis, from the Treasury if it meets a cash flow problem, and then would raise its rates the next year. If a particular insurance plan, or a cooperative plan run by doctors, went broke, the State authorities would see that its bills are paid through reserves they establish, much as they now require insurance companies to maintain reserves.

In fact, the administration has dropped the idea of establishing a national health care budget, though it argues that imposing limits on insurance premiums would serve to hold costs down. Mr. Kahn's statement referred to "premium caps and national and regional budgets."

ATTACKING PURCHASING ALLIANCES

Mrs. Clinton's attack referred only to the tag line of this advertisement, the reference to "a better way." She said the better way the industry had in mind was today's system, in which "only the healthy would be insured, or those who had ever been sick would pay a lot more."

Mr. Kahn's statement also attacked the insurance purchasing alliances that the administration's plan would compel most Americans to join—an area that has also drawn criticism from many Members of Congress. He spoke of "mandatory Government-run health alliances bogging down the system."

Mrs. Clinton defended them, saying they were the only way for Americans to get rates now enjoyed only by very large businesses that are "so big insurance companies really want their business, so they cut them a better deal, then they put the excess cost onto the small business and the individual and the nongroup market, where they make it up."

FIRST LADY TO GO ON ROAD

"We need Americans banded together," she said. "They need to be in what we call health alliances where the rich, the poor, the small business, the individual—everybody is in it together, just like we used to do insurance."

She said this was "very threatening to those who currently control the insurance market."

Mrs. Clinton told he pediatricians: "It is time for you and for every American to stand up and say to the insurance industry 'Enough is enough. We want our health care system back.'"

[From the Wall Street Journal, Nov. 2, 1993]

WHAT MRS. CLINTON DOESN'T UNDERSTAND ABOUT INSURANCE

[By William Tucker]

When Hillary Clinton finally lost her composure on Monday and accused the insurance companies of greed and of bringing us "to the brink of bankruptcy," her remarks said two things about the Clinton administration's health care proposals—neither of them very flattering.

First, they illustrated what might be called the Iron Law of Price Controls. This is that the people who are targeted by a price control must eventually be demonized and made into "enemies of the people." Think of New York landlords, or of oil company executives during the "energy crisis." This kind of opprobrium now awaits doctors and insurance companies.

More important, however, Mrs. Clinton's outburst indicates that, despite the administration's well-meaning effort to correct some obvious inequities in the insurance market, she and her husband have not yet really grasped the true nature of the problem.

Mrs. Clinton faulted insurance companies for screening out unhealthy people because "the more they can exclude, the more they can make." In his September health care speech, President Clinton cited a Florida small-business owner who had his policy canceled because two of his employees—his mother and father—had become too old. Everyone knows these stories and finds them appalling. A friend of mine had a construction-worker father whose net worth of $300,000 evaporated when the insurance company wouldn't cover his cancer. "All we had left was enough for a funeral," he says.

But is it simply insurance company "greed" that leads to these outcomes? After all, we don't have the same problems in fire, auto or other types of insurance. The

answer lies in the peculiar way we have tied health insurance to employment—a policy that, unfortunately, the Clintons want to "build in" to their brave new world.

Insurance is based on pooling risks. The vast majority of people who remain healthy subsidize those few who suffer severe illnesses. If insurance companies calculate the odds right, the premiums from those who stay healthy will cover the costs of those who get sick, with perhaps a little left over. (Traditionally, insurance companies make their profits not from underwriting but from investing the premiums they hold.)

The key to success in underwriting is to widen the pools of healthy people so there are enough to cover the seriously ill. Insurance companies generally take individual policyholders and combine them into large pools. These pools are then further widened by selling reinsurance.

The problem we have today is this: Because health insurance is a tax-free benefit of employment, insurance companies have found it profitable to offer "group rates" to the relatively healthy people who make up the work force. True, an occasional paraplegic spouse or chronically ill child slips into the pool, but generally working adults are healthy on a self-selected basis.

In fact, the economics of carving out low-risk pools of working people are so attractive that large employers have dispensed with the underwriting companies and opted to insure themselves. This process has been vastly supported by the Employee Retirement Income Security Act (Erisa), which exempts self-insured companies from State regulation and more important—from high-risk pools the States have established for people with pre-existing medical conditions. Among companies with 500 to 1,000 employees, 63 percent self-insure; from 10,000 to 20,000 it rises to 87 percent.

Insurance is very much like a game of Old Maid. The idea is not to get stuck in a pool with unhealthy people. The employer-based insurance system, along with the protections offered by Erisa, has allowed almost half the population—mostly major corporations and their unionized employees—to opt out of being pooled with the unhealthy. Washington State, for example, is now delaying its plans to set up a high-risk pool for extremely sick people because half the employees in the State (including all of Boeing) can escape the pool through Erisa.

Once these major company employees are removed from the pool, who is left? Only employees of small businesses, the self-employed and the unemployed—plus the various people with serious medical conditions who are not eligible for Medicaid or Medicare.

Left with this much narrower pool, insurance companies have pursued two strategies. First, they "cherry pick," screening people carefully to form small pools of relatively healthy people. (This is the source of Mr. Clinton's Florida anecdote.) Second, they offer a vastly inferior product: health insurance that is nonrenewable from year to year and thus allows them to discontinue coverage when people get seriously ill. No other insurance field has this problem. After all, life insurance companies can't cancel your policy as you approach death.

The solution to these anomalies would be to widen the risk pools by: (1) knocking away the tax advantages to employer-provided insurance and (2) eliminating the Erisa exemption. Yet the Clintons are moving in exactly the opposite direction. They are: (1) trying to force everyone into an employer-based system and (2) allowing larger employers, once again, to opt out through self-insurance.

Given the certain failure of this strategy, the Clintons will be left only with their ham-fisted efforts at price controls—plus the continuing demonization of doctors and insurance companies.

HEALTH CARE REFORM

Cost Containment

MONDAY, NOVEMBER 8, 1993

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. The Subcommittee on Health and the Environment will come to order.

Today we will examine President Clinton's proposals for health care cost containment that are included in this draft legislation. Last week we focused on the new institutions that the President is proposing to establish: Regional Health Alliances and a National Health Board. This morning we will look at the key purpose for these new institutions to guarantee private purchasers that the rate of increase in the health care spending will come down to the rate of inflation by the year 1999.

This is the first presidential proposal to restrain health care costs since President Carter sent to Congress his cost containment initiative in 1978. At that time, Congress rejected his plan and choose to rely on the market to limit health spending increases through the hospital and medical industry's "voluntary effort." As we know, 15 years of unrestrained growth in health care spending followed.

President Clinton has given us an opportunity to revisit this question. He has proposed to restrain the rate of increase in spending not just on hospital services but all the services to which Americans would be entitled under the health care reform bill. He has proposed to do this in the context of guaranteeing coverage to comprehensive benefits to all Americans.

To restrain growth in the cost of health coverage, the President would rely on competition among health plans within Regional Alliances established by the States. If this "managed competition" does not bring the desired results, the President would apply limits on the rate of increase in health plan premiums. These limits would be set by the National Health Board according to a formula prescribed by the Congress and would be enforced through each Regional Health Alliance.

There are critics of the President's cost containment strategy, and we will be hearing from some of them today. Some will argue

for a pure "managed competition" approach without any backstop in the event market forces fail. While the advocates of pure "managed competition" have the obligation to show that a restructured market alone—without any upper bound on health cost increases—will guarantee that universal coverage will be affordable.

Before calling on our first witness, I would like to recognize the distinguished ranking minority member of the subcommittee, Mr. Bliley, for his comments; and then I will recognize other members as well. Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. Today we begin a series of hearings which will examine in detail the following cost containment aspects of the President's health care proposal: The CPI premium cap on private health insurance, the budgetary cuts and caps in Medicaid and Medicare, and the capped subsidy payments for small businesses and low-income families.

I would also point out that today's hearing is the "flip side" of next week's hearing on the financing aspects of the Clinton health care plan. As we proceed today, we should keep this in mind: The cost containment features of the Clinton plan are also its primary financing mechanism. If any of the major cost containment features of this plan were changed, or more importantly, if any of the estimates of entitlement savings prove inaccurate, the overall financing of the health care plan would fall apart like a "house of card." Why? Because it is the CPI premium cap and the Draconian Medicare and Medicaid cuts which are supplying over two-thirds of the plan's financing. If the entitlement and other cuts do not materialize, the Federal budget deficit will explode like a super-nova. If the Congressional Budget Office and HCFA estimates prove to be wrong, and based on past experience, that is a certainty, hundreds of billions of dollars will be added either to the budget deficit or the tax burden on the American public.

With regard to the premium cap, let me quote from Dr. Stuart Altman's written testimony: "It should be understood, Mr. Chairman, that a CPI target would create a tighter spending control system than that of any other nation." This is a point I first addressed to Mrs. Clinton at our hearing on September 28th, when I used this chart comparing international growth rates. I pointed out to her that in the 1985-1991 time period, the British nationalized health care system grew at an annualized, per capita rate of 3.84 percent above inflation, and the Canadian single-payer system grew at an annualized, per capita rate of 3.58 percent above inflation.

My question to Mrs. Clinton was simply this: No nationalized system has come even close in limiting spending to the CPI, and in the case of Britain and Canada, we are talking about systems that explicitly ration care. How is the administration's plan going to accomplish these extraordinary reductions in health care spending, when even systems that ration have not remotely approached these spending limits?

Since that first hearing, I have asked Secretary Shalala and other administration officials the same question. At this point, I have not received a satisfactory answer. The fullest answer was given by Mrs. Clinton. She said that Dr. C. Everett Koop had told her that there were $200 billion of wasteful and unnecessary costs

in the U.S. health care system; $200 billion would represent approximately 20 percent of all national health care expenditures.

When Secretary Shalala testified before us, I asked her to document some of the $200 billion of unnecessary costs in the system. She was able to document only a small fraction—$1.5 million, to be exact. Maybe Mr. Thorpe can use his oral testimony today to document the $200 billion figure, and more importantly, show us how we are going to become the slowest growing health care system in the Western world without rationing health care.

Finally, let's look more closely at the plan's financing. For the time period of 1995 through the year 2000, Medicare and Medicaid are cut approximately $200 billion. During the same period, the health care programs of the veterans, the Department of Defense, and Federal employees are cut approximately $200 billion. During the same period, the health care programs of the veterans, the Department of Defense, and Federal employees are cut approximately $40 billion. These cuts represent roughly 60 percent of the new financing in the Clinton plan. These cuts are then used to buy new benefits or provide subsidies to small businesses and low-income individuals. Therefore, the "savings" from the entitlement cuts are already spent. The critical question is, will the entitlement savings ever materialize?

History is the best guide. Let's look at this chart which compares the CBO Medicaid and Medicare baselines in January 1991 and January 1993. The top line is the January 1991 CBO Medicaid baseline calculated on the statutory changes made in the 1990 reconciliation bill. CBO initially estimated that total Medicaid spending for the years 1992–1996 would be $363 billion over 5 years. During their January 1993 reestimate, the equivalent baseline had grown to $463 billion, a $100 billion increase. An identical analysis of the Medicare baseline shows a $51 billion increase over 5 years. Therefore, we can say that the initial Medicaid/Medicare estimate of the 1990 reconciliation bill was off by a staggering $151 billion over 5 years.

Now let's look briefly at CBO's ability to estimate the cost of new benefits. Let's look at what occurred during the short life span of the Medicare Catastrophic Coverage Act. When the Act passed Congress, the official CBO estimate for the new benefits was $30 billion over 5 years. One year later, CBO reestimated the cost of the benefits at $48.3 billion, a whopping $18.2 billion increase in less than a year. And let me remind my colleagues that some of the major benefits had not even been phased in yet.

These two examples are representative of many others and point to two principles of Federal budgeting: CBO tends to grossly underestimate the cost of new benefits, and tends to dramatically overestimate the "savings" that can be "squeezed" from the health care entitlements.

If we apply these principles to the Clinton plan, we can begin to understand that the plan may not only irreparably damage the world's greatest health care system, but could also simultaneously send the Federal budget into a "black hole."

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

[The charts used by Mr. Bliley follow:]

Average Annual Growth in Per Capita Health Expenditures

(Adjusted for Inflation, 1985 - 1991)

Country	% Increase (1985-1991*)
Turkey	9.61
Spain	6.69
Italy	5.55
Finland	4.97
Iceland	4.48
Luxembourg	4.41
Norway	4.30
Japan	4.24
Belgium	3.95
United Kingdom	3.84
Canada	3.58
Portugal	3.41
France	3.26
Austria	3.05
Netherlands	2.94
Ireland	2.67
Greece	2.26
Australia	2.08
New Zealand	2.06
Germany	2.05
Denmark	2.03
Switzerland	1.82
Sweden	0.48
United States	**0******

* Numbers are the percentage by which the increase exceeds the rate of inflation, as measured by the GDP inflator.
** Number as presented in 9/7/93 Administration Proposal.

Sources: Organization for Economic Cooperation and Development, 1985-1991 comparison; Working Draft - Clinton Health Care Plan, 9/7/93.

CBO Baseline Projections For Medicare & Medicaid

(by fiscal year in $billions)

Medicaid

	1992	1993	1994	1995	1996	Totals
Jan. 1991*	$57	$64	$72	$80	$90	$363 billion
Jan. 1993**	$68	$80	$92	$105	$118	$463 billion
Difference, 1993-1991	+11	+16	+20	+25	+28	$100 billion

$100 billion added to Medicaid CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

Medicare

	1992	1993	1994	1995	1996	Totals
Jan. 1991*	$127	$140	$156	$173	$194	$790 billion
Jan. 1993**	$129	$146	$167	$188	$211	$841 billion
Difference, 1993-1991	+2	+6	+11	+15	+17	$51 billion

$51 billion added to Medicare CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

* *The Economic and Budget Outlook: Fiscal Years 1992-1996*, January 1991, Congressional Budget Office, p. 91
***The Economic and Budget Outlook: Fiscal Years 1994-1998*, January 1993, Congressional Budget Office, p.49

Medicare Catastrophic Coverage Act, and its Repeal

	Outlays 1989-1993		*Difference*	
	*June 1988 Estimate**	*August 1989 Estimate***	*$*	*%*
Prescription Drugs	$5.70	$11.80	$6.1 billion	207%
Skilled Nursing Facilities	2.10	13.50	$11.4 billion	643%
HI (Non-SMF)	7.40	7.80		
SMI (Part B)	14.90	15.20		
Total	30.10	48.30	$18.2 billion	

All amounts in $billions.

*Official CBO cost estimate when Medicare Catastrophic Coverage Act (MCCA) enacted

**Aug. 1989 CBO memo on reestimating MCCA prepared for Senate Finance Committee

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. I think this is an extremely important hearing. Cost containment is very much on Americans' minds.

I have great reservations about two of the central plans in the administration's health reform proposal both on a matter of premium caps and on the unprecedented Medicare and Medicaid spending reductions. I think this committee needs to examine both of these in great detail.

For example, it seems to me that premium caps without consumer safeguards and flexibility are a true prescription for a train wreck. I hope we will have a chance to discuss with Dr. Thorpe, for example, what would happen when a plan bumps you against the insurance premium limit. How will they make decisions with respect to what services will be compensated for and what technologies will be used and other areas that fuel costs.

On the matter of Medicare and Medicaid savings, I think the level of reductions that are proposed truly threaten access to health care in this country for elderly and poor people. It seems to me the nature of the proposal, as we have it now, suggests that all administrative costs are created equally. I think the evidence that we have picked up—and I got a General Accounting Office report this summer with respect to Medicare part B carriers—indicates, for example, that there are not adequate funds at this point to train people properly to do medical reviews. We may need to be spending more on some of these areas to be sure that senior citizens have their rights protected.

So this is an especially important hearing, Mr. Chairman. I look forward to working with you and our colleagues.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. I will be brief. I would like to again welcome Mr. Thorpe to the Hill. He appeared before the Budget Committee last week and presented some rather interesting information.

We have an opportunity here again today to examine further financial assumptions in the Health Security Act and the implication of those on the Federal Government, State governments and the American people.

What Mr. Thorpe did, I think by request, resulting from a hearing the previous week with Secretary Bentsen and other hearings, was to present us with a funds flow statement as to how they saw costs and revenues working out in the President's plan. I think this is a good start. I think they have made a diligent effort to get that information to us. There are obviously some assumptions in there, some of which I hope we will examine and hear more about today.

I will not reiterate what Mr. Bliley has just said pointing out the difficulties that our government is having in projecting the cost of medical care programs. The examples of Medicare and Medicaid being $150 billion off in just 2 years of projections from January of 1991 to January of 1993 demonstrates how out of control those programs are, the way they are funded. I don't think it is so much a lack of ability as someone to intelligently project costs if the con-

ditions and terms under which those programs operate are clearly defined.

The problem with Medicare and Medicaid is that there is no real specificity in terms of what the programs are. So they are, in fact, open-ended entitlement programs.

I think what we have to look at when we look at health care reform is what are we going to be doing in terms of what we add in terms of specificity and open-endedness because the percentage arrow that existed in that 24-month period, which is 12 percent, if we extend that to added benefits included in the Clinton plan, it will amount to a $24-billion-a-year error.

If you ally it to the total of Federal and State programs and the mandates implicit in the Clinton bill, it amounts to a $100-billion-a-year error.

So this is not to be critical. It is to simply say that with respect to the administration's plan, or for any other plan for that matter, whether it is the Cooper-Grandy bill, the Republican alternative, or the Chafee plan, we need to be very careful about how we go about estimating the potential cost.

I would just add one more thing to that. Even if we don't have a plan, we still have the same problem of a lack of specificity because Medicare and Medicaid, the way they are structured today, are very likely to produce similar margins of error in the future.

So health care reform is not just a matter of projecting. It is a matter of getting specific about what the Federal benefits are precisely and setting them up in a way that they don't run out of control.

So I welcome again Mr. Thorpe and look forward to your testimony.

Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman. I too look forward to Dr. Thorpe's testimony.

I also had the opportunity to sit in on the hearing before the Budget Committee and heard his testimony at that time.

I thought it was ironic in some of the comments that were posed as part of the introduction here, Dr. Thorpe; I have the feeling that some are criticizing not whether you are going to be successful in being able to hold down inflationary increases, but perhaps that it will work too well, that in fact we may be successful—if the numbers are compared to countries like Turkey, Spain and Italy, for example.

It is somewhat ironic that we are already spending twice as much as Japan and 40 percent more on health care than Canada. We are hearing right now we cannot hold down our cost increases for fear that we cannot maintain this megaleap in spending on health care over every other country in the world. Yet, almost every single country that was listed is providing universal coverage presently.

We have a challenge before us. If we do not contain spending in this country, then indeed none of us can experience the quality of health care that many of us experience today. It is the future that we are looking to, not the present situation.

The quality of the America's health care system is one that we all prize. But it will not continue to exist for an increasing number of Americans if we do not succeed in providing for appropriate cost containment.

Dr. Thorpe, I look forward to your comments. I am sure there is room for questioning and probing and trying to come up with the best solution.

All the members agree that the status quo is unacceptable. We have to win in this battle, and this battle means controlling health care costs so we can guarantee quality choice, with security, for all Americans tomorrow.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Moorhead?

Mr. MOORHEAD. I have no statement.

Mr. WAXMAN. Without objection, all members will have an opportunity to insert an opening statement in the record.

Our first witness is Mr. Kenneth Thorpe, Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services who will address the impact of the cost containment provisions.

Prior to joining the Department of Health and Human Services, Dr. Thorpe held faculty positions at Harvard and Columbia Universities and the University of North Carolina.

Dr. Thorpe appeared before this committee in 1980 to discuss the impact of AIDS on spending.

Your prepared statement will be in the record in its entirety. We would like to urge you to try to keep the oral presentation down to about 5 minutes.

STATEMENT OF KENNETH E. THORPE, DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THORPE. Thank you, Mr. Chairman and members of the committee, I am pleased to be here today to discuss with you the cost containment provisions of the President's Health Security Act.

First, I will discuss the cost of doing nothing to restrain health care spending for employers, governments, and families. It is because these costs are so high that we believe a strong cost containment strategy is critical to the success of comprehensive health reform.

Second, I will discuss the cost containment strategy in the President's plan.

Why must we remain committed to a strong cost containment strategy? Because the total costs of health care are high and rising.

In 1992, the United States devoted 14 percent of GDP to health care. In 1980, the share was 9 percent. No other country in the world spends more than 10 percent of GDP on health care. If we do nothing, it is estimated that health care spending will consume 19 percent of GDP in the United States by the year 2000.

Over 40 percent of the growth of real per capita GDP between 1993 and 1996 will be accounted for by health care spending. While some of this growth is warranted, this unusually high rate crowds out other items of consumption.

Health care cost growth will continue to outpace growth in other segments of the economy. While the annual growth in the non health care sectors of the economy for the rest of the decade is projected to be between 4 and 6 percent:

Private health care costs will grow at a rate between 7 and 8 percent;

Medicare growth will be 11 percent, and

Federal Medicaid growth is expected to be over 16 percent in 1994, and to slow to only 12 percent over the remainder of the decade.

The rising costs of the current system harm business, government, and families. Businesses pay for health care primarily through premium contributions for health coverage and workers' compensation.

Real business spending on health care has risen from $774 per employee (in 1992 dollars) in 1970 to $2,345 in 1992, a 200 percent increase.

Real workers' compensation premiums per employee have more than doubled since 1970, rising from $149 (in $1987) in 1970 to $326 in 1992. Health care costs are the fastest growing component of workers' compensation premiums.

On average, the uninsured currently pay for just 20 percent of the care that they use. The other 80 percent is shifted to people who are privately insured, resulting in higher premiums for businesses and families.

High health care costs tie up money that would have been used for wage and salary increases, capital expansion, profits, and payments to shareholders. In addition, our current health care system is a growing burden on all levels of government, and is the greatest barrier to deficit reduction.

Government spending accounts for 44 percent of health care spending in this country. This includes the costs of Medicare and Medicaid and the costs of providing health care for government workers. Almost two thirds of the growth in all Federal spending between 1993 and 1996 will be for health care.

As health care continues to consume a larger share of the Federal budget, Federal spending for other goods, such as education, training, employment, and social services will actually decline as a share of total Federal spending over the next 5 years.

The bottom line for workers under the current system is that they ultimately pay for the growth in health care spending. One of the reasons that real wages have barely grown for the past 20 years is the increased costs of health care for businesses.

If employer contributions to health insurance remained at their same share of employee compensation between 1992 and the year 2000, and employers passed these savings on to workers, real wages per worker would be $566 higher in 2000 than they are currently projected to be.

We cannot achieve meaningful cost containment without comprehensive reform. Cost containment efforts over the last 20 years, public and private, have done little to reduce the spiralling rate of growth in the health care sector of our economy. In today's system, cost containment efforts by one payer often just shift costs to another. Employers and other payers, faced with uncontrollable

health care expenses, are being forced to reduce benefits, limit choice and increase the share of expenses paid by their employees. Without the guarantee of a universal system, including a comprehensive cost containment strategy, the unrestrained growth of health care costs will threaten health security for us all.

Even with health care reform, health spending will continue to grow. The important differences, however, are that with reform, the increase in spending will be accompanied by (1) universal access; (2) enhanced benefits for millions of Americans, including older Americans; and (3) a coherent cost containment strategy that assures affordable levels of growth into the future.

The President has a three-pronged approach to cost containment. First, the plan restructures the health care market place, providing consumers with information to make informed choices. In this reformed marketplace, health plans will compete on price and quality. Second, as a back up strategy, the plan includes caps on the permissible rate of growth of health plan premiums. Third, the plan reduces the rate of growth in the Medicare and Medicaid programs.

To facilitate competition, the Health Security Act creates regional health alliances. These alliances will act as the purchasing agents for workers in firms with less than 5,000 workers, for those who are self employed, and for those who have no attachment to the workforce. In addition, some large firms may opt into the regional alliances. Alliances will provide consumers with even greater choices than those enjoyed by employees in large corporations in today's market.

Under the current system, large firms can promise substantial market shares to insurance plans in return for lower premiums. However, those in small or moderately sized firms are often unable to obtain reasonably priced premiums because insurers view each firm as being relatively unimportant to their market share.

Individuals attempting to purchase insurance outside of an employer group have an even more difficult time in their attempts to purchase independent policies.

Health alliances act as buying cooperatives to organize the health insurance market on behalf of their members. Health plans that want to participate in the market place will have to compete honestly over price, quality, and service. By eliminating the ability of insurers to discriminate based on health status and age, the President's plan moves the health care environment in the direction of a more competitive market, which will reduce waste in the system and drive premium prices downward.

The President's plan also provides incentives for consumers to make cost conscious decisions about their health care coverage. Consumers who choose to enroll in higher cost plans will pay more for their insurance than consumers who opt for lower cost plans.

An example of how such incentives to consumers will work under the reform plan is the experience in the State of Minnesota. In the mid 80's, Minnesota changed its contribution for the State's employees from 100 percent of the State high cost plan to 100 percent of the low-cost plan serving a given county. Between 1988 and 1990, the percentage enrolling in the State high cost plan fell from 43 percent to 12 percent. Those enrolling in the low cost plan in-

creased from 25 percent to 45 percent during that period. System expenditures in the Minneapolis region were 6 percent lower than they would have been if no plan switching had occurred between 1988 and 1989.

Alliances have another negotiating tool information. Data about practice patterns, price and quality differentials from one plan to another and from one metropolitan area to another allow alliances to compare plan and area performance. By expanding the information base, competition drives high cost, high utilization areas to bring their performance more in line with other areas. As utilization and costs decrease, this translates to lower prices for business, government and families.

An example of how this information can help to drive costs down is the case of the new California Health Insurance Plan Cooperative (HIPC). California HIPC, a voluntary pool for firms between 5 and 50 employers, informed high and low bidders (health plans) of the relationship of their first bid to the average. Among those who were informed that their bid was above average, close to 30 percent gave second bids that were lower by an average of nearly 10 percent. No bidder, even those whose bids were below average, raised its bids. Initial evidence in Florida is similar to that in California.

The Health Security Act also contains costs by reducing administrative expenses, both for health plans and for health care providers. Administrative expenses for individual and small group insurance can amount to up to 40 percent of premiums. Health care providers spend millions of dollars on inefficient claims processing systems, including the time costs involved in filling out multiple forms. Through alliances, administrative costs for insurance will be far lower than they are today. In addition, the President's plan simplifies claims administration by developing a uniform claims form and electronic billing system.

The Health Security Act saves money by taking aggressive steps to combat health care fraud, increasing penalties for those who cheat the system and expanding enforcement activities. It imposes new prohibitions against kickbacks and conflicts of interest, such as doctors who refer patients to laboratories in which they have a financial stake. And health care providers convicted of fraud and related crimes will be excluded from participation in health plans.

Through these changes in the competitive market, the Health Security Act restrains the growth in health care spending. To ensure that these changes achieve savings, we create a backup system of enforceable premium caps. These caps will still allow spending to increase, but by a much more reasonable amount one much closer to the rise in other consumer prices. These premium caps are not designed to restrain the marketplace, but only to act as a backstop, guaranteeing reasonable and defensible expectations for savings. The caps are based upon projections of savings in administrative costs and from increased price competition in the alliances. We believe insurers and providers can achieve these savings, and hold premium growth closer to price increases in the rest of the economy.

Premium caps are enforced through an automatic mechanism in the legislation. If premiums in an alliance exceed the cap, alliances

may negotiate with health plans to bring premiums in line. If premiums cannot be reduced through negotiations, automatic premium reductions are triggered, and provider payments from plans are similarly reduced (with adjustments for expected increases in volume of services).

Medicare: Under our plan, by fiscal year 2000 we will have reduced the rate of growth in Medicare from its current annual rate of 10.7 percent per year to about 8.4 percent even while adding new coverage for prescription drugs.

Medicaid: The Health Security Act will provide all Americans with health coverage, and therefore it will nearly eliminate uncompensated care. This will allow a replacement of Medicaid disproportionate share payments with a much smaller special reserve of funding to be directed toward hospitals that treat large numbers of low income populations, including undocumented persons. In addition, Medicaid recipients will be receiving health care services in alliance health plans, like other Americans with private insurance, where costs are constrained.

In conclusion, let me reaffirm the President's commitment to bring the rate of increase in health care spending in line with the rate of growth in the rest of the economy. The Health Security Act proposes a market based mechanism for controlling health care costs, backed by enforceable premium caps and fee schedules for fee for service plans. We understand that controlling costs requires tough choices, but the consequence of doing nothing means that health care spending will continue to rise unrestrained, threatening health security for us all. I would be happy to answer any questions you may have.

Mr. WAXMAN. Thank you very much for your testimony.

The two central features of the administration's proposal are that we are going to have universal coverage and effective contribution. Under the President's proposal, all Americans would have access to guaranteed health care coverage and the President is asking that employers and workers bear much of the cost of this universal coverage. So, understandably, if employees and workers are going to assume this responsibility, they want to know what their financial obligations are going to be and that it not be open ended.

The President obviously considered and rejected the idea of solely relying on managed competition or market forces to limit the rate of increase in health care costs. Instead, he has proposed managed competition with a backup system of enforceable premium caps.

Can you tell us why the President thinks premium caps are necessary to make universal coverage affordable? Why doesn't he rely on market forces?

Mr. THORPE. For a couple of reasons. The most fundamental is that for too long we have been on autopilot. If you look at the growth in health spending in this country relative to any other country in the world, we continue to spend more per year, more as a share of our income, despite the fact in some pockets we seem to have a lot of competition, but it seems to be competition without limits.

I believe the President's plan with respect to providing backup guarantees is important in a couple of respects. It provides a safeguard to the American public that this health care delivery system

is not on autopilot. There are safeguards and guarantees for families and employers, as well as the Federal Government, with regard to how much money we will spends on health care.

Mr. WAXMAN. Does it indicate a lack of confidence by the President that the market system will work?

Mr. THORPE. Let me give you a couple of analogies, because I think that competition is really most effective within limits.

If you look at any business in this country, when it goes to undertake any type of major project, that project has a budget. That does not mean that the individual within the corporation who sets up the budget is telling the purchasing manager how much to pay for staples and paper clips.

I think providing discipline so the marketplace can operate with some discipline is essential. If you look at areas of effective competition, making the budget goes together hand in hand.

Competition can be most effectively played within limits and a set of budgeting.

Mr. WAXMAN. Those who say they want pure managed competition look to the California system where California employees are covered and plans are put together to compete for consumer choice, but CalPERS also says, this is the amount of money we are going to provide for increases and they limit it.

Is what you are doing similar to what CalPERS does?

Mr. THORPE. There are some similarities. CalPERS has recently set target for how much they want spending to rise. I think the similarities are that we are setting a reasonable target rate of growth. That target rate of growth, we believe, is easily achievable within the set of negotiations that will go on within our system between health plans and health care alliances.

Mr. WAXMAN. What if you are wrong, that what you consider the reasonable target growth turns out to be not reasonable at all and, in fact, the growth is much larger than what is expected? I assume the alliances negotiate with the plans to try to get them to hold down their premiums for the next year. They also have a way to say if they can't negotiate successfully that they can mandate that the premiums on the higher priced plans be constrained to reduce those high-priced plans that are above the average.

What will happen to those higher-priced plans? How will they respond? Will they be able to shift the costs for more cost-sharing for the patients today, or will they have to absorb it, ration care?

Mr. THORPE. The families are safeguarded and guaranteed that they cannot absorb higher levels of cost-sharing. Plans cannot make adjustments by imposing higher rates of cost-sharing on families.

Plans that are high priced, less effective and inefficient will have to negotiate better deals with providers or, second, advise their networks that they will have to do a better job of providing high-quality care. That is where the areas of adjustment will be.

Plans that are less efficient in the market could also see migration away from them. So, there will be several signals for plans that are substantially above cost to do a better job of negotiating or managing the care that they provide. They can provide the adjustments by changing what they provide to consumers and individuals.

Mr. WAXMAN. Thank you.

Mr. Bliley.

Mr. BLILEY. Mr. Thorpe, I would like to ask you several questions concerning section 6001 of the bill, which is the computational formula for annual update to the premium cap. I would like you to turn to pages 968 and 969. First, I would like to clarify exactly how the premium cap inflation factor update would be calculated.

According to the statutory language, the premium cap will be fully phased in at the Consumer Price Index by the year 1999. For the years beginning in 2000, the National Board is told to submit a recommendation to Congress. If Congress does not act, the Board must calculate an inflation factor update, based on a formula specified in the statute at section 6001 a(3)(C) on page 968. The formula is specified as the product of CPI, population change and real GDP growth. It is the addition of CPI, population and the real GDP per capita growth.

My first two questions are: Do we multiply the factors or do we add them; and second, is the population growth factor redundant because the entire premium cap is already calculated on a per capita basis?

Mr. THORPE. Let me see if I can clarify on page 968 with respect to the formula. The formula applies to health insurance premiums. After everybody has received health insurance, the target will be CPI plus population plus 1.5 percentage points.

[The information follows:]

The bill has been clarified on pages 986 and 987 to indicate that the factors in the inflation factor update formula should be multiplied. Further, the population factor has been removed because population growth is included in the per capita cap.

Mr. THORPE. If you look at the actual growth in health spending between 1995 and the year 2000, it would obviously be higher than CPI, plus population plus 1.5 because we are providing health insurance for the uninsured and under-insured populations. So these numbers do apply to premiums once everybody has received health insurance coverage.

Second, with regard to the long-term growth rate, the attempt is to make a distinction between the short-term rates, and we believe for two reasons they are easily achievable. One is that we have more spending in the system; second, there is a substantial amount of one-time savings in the system that our plan will receive.

Mr. BLILEY. In all due respect, is it addition or multiplication? Do we add the factors or do we multiply them?

Mr. THORPE. With respect to the long-term growth, the intent of the long-term growth is to have health spending rise at zip; and population growth and factors of productivity and aging. Technical mistakes in the bill as introduced will be changed.

Mr. BLILEY. Now I would like to explore with you some of the possible reasons why the default formula for the outyears drops dramatically. This is based on the formulas in 6001(A) and the population change in the GDP growth from September 1993.

We can see it declines to 2.7 percent in 1999. When the cap is fully phased in in the year 2000, under the default formula, the cap

jumps to approximately 5 percent. This is substantially greater than the CPI.

The premium phases from 4.2 to 2.7 percent in 1999, then jumps dramatically to 5 percent under the default formula in 2000. I find that most peculiar.

Let me give you two explanations, first the year 2000 is outside the CBO budget scoring window. That means that if Congress enacts a bill next year, CBO by its scoring rules, does not evaluate the financial impacts in the year 2000 and beyond. Therefore, the administration could rapidly increase that factor without any paying or budget problems. It shows the administration clearly understands that the CPI cap was unrealistic, but the administration needed the scorable savings that the CPI cap generates to finance the plan.

Once we are out of the 5-year budget window, the cap increases dramatically. Would you please comment?

Mr. THORPE. With all due respect, Mr. Bliley, I think the numbers you put forth are not the numbers we are using. We are using 3.5 in the calculations. That rate of growth is for the year 1999. The year 2000 growth, as I mentioned, is to account for the long-term growth in the system once we have made our investments and taken our one-time savings out, as well as putting a substantial amount of new spending in.

We have made a sharp distinction between the short-term and the long-term growth. The short-term growth, in actual health care spending between 1995 and 2000, is not 3.5. Again, the reason is that there is a substantial amount of new spending coming into the system. The actual rate of growth in the health care system between 1995 and 2000 would not be substantially different compared to what we were going to spend after the year 2000.

Mr. BLILEY. Thank you.

Mr. WAXMAN. Thank you.

Mr. Wyden.

Mr. WYDEN. We are going to have to score all this stuff, as you know. Does the Congressional Budget Office and the Office of Management and Budget tell you folks that competition will do more to slow health spending than would the premium caps?

Mr. THORPE. Well, I cannot speak for the CBO. We in the administration certainly believe that the President's plan with respect to competition will slow the rate of increase in private health care spending.

We have spent several months putting together our best guesstimates of the achievable savings in the private sector from competition. They include areas of administrative savings, areas of plan-switching and cost-conscious choice. The literature out there has documented a substantial amount of inefficient and inappropriate medical care.

For the committee's reading, I would be happy to provide the litany of empirical studies the RAND Corporation has done over the years, outlining the inappropriate and inefficient provision of medical technologies.

Mr. WYDEN. The Congressional Budget Office has raised real reservations about how much money pure competition would save. I personally think you get your savings through premium caps rath-

er than competition; the way you have set up the premium caps, I think they can be gamed. I think in the way they are going to be gamed, it could undermine market incentives. I think the plans will raise their premiums to the maximum extent allowed, and the marketplace incentives will go out the window.

I think we could look at a proposal to build flexibility in here. What would you think of an idea of allowing plans to bank or store up a limited amount of spending authority for premium increases coming in under the budget premium? This way, we would not get into a situation where premium hikes shadow the caps. We could do it over a rolling time period and not get into this situation where we undermine the market incentives.

Mr. THORPE. I guess my view of this is that, again, with the targets, at least from my understanding of the works I have read in industrial organization and market structure, there will be two things occur. There will be a substantial amount of price variation as plans start to niche themselves into boutique firms, as well as lower-cost firms, to attract market share. I think in the first several years of this plan there will be a lot of aggressive bidding in the market, to come under the rate of increase in the market, to generate market share. I think you will see that with respect to premiums.

Second, as you remember, even for plans in a particular year that do have low premiums, they will be protected because the premium increase is indexed to an average.

Mr. WYDEN. I have seen these numbers thrown around so continually and with differing estimates, it would be good to get it clear.

What is—is the cost of new Medicare and Medicaid spending real, relative to the spending cuts?

Mr. THORPE. Are you talking about prescription drugs?

Mr. WYDEN. Yes. I want to see how much we are going to spend new on Medicaid and Medicare relative to how much the spending cuts are coming to.

I think Medicare and Medicaid will be used under your proposal to cover the deficit. I don't think the American people will be wild about that idea. Maybe you can enlighten us.

Mr. THORPE. We think it is critical to be sure that if we are going to control the health care spending that you apply equal pressure on public and private health care spending.

Having said that, Medicare is still going to grow at 8.4 percent per year higher than what you will see in the private sector.

Mr. WYDEN. Mr. Chairman, can I get an answer to that question? How much is going to be cut from Medicare and Medicaid and how much is going to be spent on new programs?

Mr. THORPE. The Medicare proposed savings are $123 billion during the time period of 1996 to year 2000. The Medicare drug benefit program will add about $66 billion to spending.

The home and community-based care program, I could not give you a precise number right now because many seniors will be eligible and qualify for that program. The total expense of that is $57 billion over that time period.

Mr. WAXMAN. Mr. Wyden, your time has expired. We will have another round.

Mr. McMillan.

Mr. MCMILLAN. There are some numbers on the chart that we handed out to you that would cover that, at least in general.

You know, I think a lot of what you said in your statement I agree with. I think there are going to have to be caps whether we have health care reform or don't, if nothing more than to force Congress to make decisions about specific programs. They are left open ended and we need the legislation to do that.

Most people are scared of it. The fact is, it has to be addressed whether we have reform or we don't.

I want to get to the area of specifics. I think the gentleman from Oregon was beginning to get at it on the fact that we probably add more for Medicare-eligible beneficiaries than we reduce when you add together long-term care and drug benefits.

But just to focus narrowly because we don't have much time, I think in your statement you list 24 specific reductions that you will recommend in Medicare, one of which is on the revenue side and has to do with some means testing.

Will you get into very specific recommendations with respect to that under Medicare alone?

Mr. THORPE. Well, a couple of things Mr. McMillan.

When Bruce Vladek comes before the committee, he can go into specific details. Let me try to give you a summary of what the proposals are doing.

First, about half of the savings would come from either extenders of savings from the previous budget discussion, as well as phasing down disproportionate share payments under the Medicare program. That is about half of the savings.

The remainder are trying to target high growth parts of the program—areas on the payment side we wanted to change.

It is important for hospital services and home health care as well. I believe they have them outlined specifically. They will be outlined specifically in the legislation. Many are really targeted on how we pay outside the hospital.

Mr. MCMILLAN. Will it get at determining what is reimbursable and what is not?

Mr. THORPE. The attempt is to look at areas in the Medicare program that are high growth. We think in several areas of the program we have done a relatively good job in slowing the rate of increase. We are trying to make some structural changes.

Mr. MCMILLAN. In your cap approach in non-Medicare is the assumption that, with a reasonable cap that takes into account reasonable force levels, then those things will happen. How do you propose to do those things under Medicare? You don't include Medicare in the same set of caps and market discipline that you think will occur under your Regional Alliances?

Mr. THORPE. That is correct. It is not under an entitlement cap.

We have specific ways of achieving a desired rate of growth, using changes in the program we have wanted to make for a long time; and that includes structure and how we pay providers.

Mr. MCMILLAN. When will those specifics be available so that we can then ask some more questions trying to get to the root of this, because this is also the issue of whether or not we can control costs.

Mr. THORPE. I believe Mr. Vladeck is scheduled to appear before the committee next week.

Mr. WAXMAN. Monday.

Mr. MCMILLAN. Thank you.

Mr. WAXMAN. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Thorpe, I would like, first off, to say that I think the concept of the premium caps is an important backstop. Also I find it somewhat ironic that some are so concerned about the impact of the savings from Medicare and Medicaid. This is almost like a dream world.

You hear talk about how we are so afraid that we might impact the cost increases for Medicare and Medicaid when there is some suspicion here that the Congress will at some point, if nothing is done, put into effect some sort of entitlement caps that would have a much, much more disastrous impact, particularly on Medicare. To think that wouldn't happen at some point in the near future if we don't reform health care is delusionary to say the least.

So I think it is important that that concept not be lost in this discussion. We cannot continue in make-believe land here as though nothing will happen if we ignore the challenges in front of us.

One of the questions on premium caps is an issue raised by several from the insurance industry, from the HIAA and the Group Health Association of America. They argue that premium caps will be too constrictive in the efforts of health plans to raise capital. I think it is true that health care is not going to be as profitable for some as it has been in the past, but at the same time they raise the issue—and I wonder how you respond to it—is there going to be a problem of attracting appropriate capital to these health care plans in the future with the prospects of having a premium cap out there?

Mr. THORPE. I really don't think that will be a major issue, and I say that for two reasons. First, we are providing universal coverage to 37 million individuals, which is going to provide a substantial increase in the volume of business. So that if you look at the actual increase in revenues into the system, will be above the projected premium caps, as the backstop that the President's plan suggests. That is the first point—the revenue flow in the system does not look like that stream that is outlined in the cap formula. Second, I think that through reforming the system, both the administrative costs, in particular, the administrative costs on the provider side—hospitals, physicians and the cost to hospitals and physicians of treating patients in a reform system where everybody is covered are going to fall.

The reason I raise the issue of cost is, just because you have a slower increase in revenues doesn't mean a slower increase or a reduction in net income, because the costs of providing goods and services in this system are going to fall.

Just an example, if you look across this country in areas of slow revenue growth, whether it is the Mayo Clinic at Rochester, wherever you look, the net income of those providers is really no different than areas of this country where you have cost growth three or four times that. So that correlation between revenue growth and

income capitalization does not exist. The final point I would make is that in the calculation we have made of the allowed administrative load that health plans can charge, which is 15 percent, that we included an estimate of capital costs. I think for those three reasons, I don't think attracting capital will be a major issue.

Mr. KREIDLER. The other question is why you chose for the first 5 years a CPI plus population growth formula. Why don't you use GDP during that period of time?

Mr. THORPE. I think that the idea was to index the growth to inputs as opposed to an output—GDP is an output measure. We thought that there was less volatility in an input base measure, first of all. Second, that if the idea was to stabilize the share of health spending as a percentage of GDP, we tried to do that at least initially through our 1.5 and 1 percent add-ons. We were looking at the input prices flowing into the system as opposed to looking at outputs as a measure.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Moorhead.

Mr. MOORHEAD. Thank you. I am sure we all are very sympathetic with the goal to control prices as far as what we pay for medical care in the United States, but with the aging of America, with the tremendous growth in AIDS cases—and certainly the predictions are not very friendly in that particular area—but with new developments that allow you to keep on your feet a lot longer by orthopedic surgery, replacing kneecaps and elbows and whatever, and certainly with all the new developments that we have in the field of cancer and other places, costs are going up.

How can we meet these goals of prices in Medicare and in our medical costs without rationing some of these medical care items that we have? People want heart transplants when they are available, lung transplants, they want all these things that the doctors and science can give to them now, and yet they are extremely expensive. Are these health providers going to have to say, no, we won't give this care, we cannot do it?

Mr. THORPE. I absolutely think not. I will raise two reasons that I have raised before.

First, there is a substantial amount of administrative savings to be had on the insurance side, hospital side, physician side. These are one-time savings, they are changes that will reduce the costs and slow the rate of increase in health care spending.

Second, if you look at the year-to-year growth in health care spending, several health service researchers have tried to break these apart into rates of increase that are clearly justified.

Due to new technologies that are cost effective, due to the aging of the population and inflation, clearly a lot of what we intend in the margin is worth it. On the other hand, what is really driving the year to year increases in the intensity of services provided to all Americans is pure waste, ineffective, and inappropriate medical care. By restructuring the delivery system, we are hoping to reduce not only the spending but also to improve the quality of care provided to our citizens.

Again, I think a lot of what you see out there in terms of being able to meet the President's year-to-year growth, we can reduce the administrative costs as documented by studies of the RAND Cor-

poration and others. They document the incredible waste and inefficiency in the system. I think that in the near term, the rate of increase in spending that we are talking about will not lead to rationing of care of any sort; rather, it will eliminate care that is ineffective and inappropriate and not needed.

Mr. MOORHEAD. I think we can all agree that there are many costs there, the defensive medicine that huge malpractice verdicts bring in. I don't see that this plan has done as much as they could do in that particular area.

Certainly, they have reached a successful way of cutting costs when they say that we are going to have a limited number of forms, we are not going to have as many forms for the doctors to fill out. But after you make those cuts—and as you say, they are a one-time item—how do you go beyond that point and make the cuts that you are going to have to make in order to make this thing balance out?

Mr. THORPE. You are correct in stating that the administrative savings that we agree we have to streamline and reduce are one-time savings. However, the way that I think we can make sure that the year-to-year growth in health care spending is slower is by focusing on the rapid growth in the intensity of services and the duplication of facilities that are in the markets.

The major reasons for going to a network-based health care delivery system is to avoid wasteful duplication and competition on the capital side and on the amenities among hospitals and health plans within the network. It is not so much the diffusion of technology into our system that is causing the problem. I am sorry—it is not so much that the pace of innovation into the system is causing the problem. The issue here is the inappropriate and duplicative diffusion of an incredible amount of technology and services among hospitals, physicians' offices and ambulatory care providers that is wasteful, duplicative, and results in increased services and use. By restructuring the delivery system, we go a long way toward avoiding unnecessary, unwanted duplication of technology and of services, and that is a major way over time to make sure that we slow the rate of increase in service intensity. Much of it is simply generated to financially justify the acquisition of a technology.

Mr. MOORHEAD. It is really in reality though——

Mr. THORPE. If I may, if you do look at the types of plans that we are talking about—again I will mention Rochester—they have achieved their savings in a different way than the President's plan has talked about, but that is a system that has all the technology that any other place in the world has, but diffusion of it within the system is much slower.

If you look at the admission rates, the utilization rates, administrative costs, the rate of increase in health care spending in that system, it is far lower than anyplace I have studied in the United States and a lot of it has to do with the way that they have structured their health system within that community. The same could be said of the Mayo Clinic as a network as well. Having an unorganized fee-for-service system that doesn't try to consolidate and develop a network-based plan of action I think will continue to lead to unnecessary duplication and increase in service intensity and rising costs in a way that we can no longer afford.

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Mr. WAXMAN. Thank you.

Mr. Synar.

Mr. SYNAR. Thank you, Mr. Chairman. Let me get some information before I ask you questions. The caps will be set by the National Board, correct? Will they be different——

Mr. THORPE. The actual—you are talking about the premium caps? They are outlined in the——

Mr. SYNAR. Will they be different for each State?

Mr. THORPE. No, the rate of increase in the average premium will be according to the CPI plus population.

Mr. SYNAR. So they are consistent regardless of the State?

Mr. THORPE. The rate of increase would be the same across alliances.

Mr. SYNAR. And there would be no variation within States on premiums; in other words, rural areas versus urban areas?

Mr. THORPE. In terms of the actual premiums themselves, sure. The way that the legislation discusses this is that the Board will make an estimate of what the costs of providing the comprehensive benefits are nationally, and then for each alliance will make adjusters across regions.

Mr. SYNAR. The National Board sets a standard. The State will then take that standard and have some variations and they can make variations within the alliance?

Mr. THORPE. No. The National Board will make them for the alliance. The State won't make the adjusters. It is done by the National Board.

Mr. SYNAR. Will the Oklahoma health care alliance be able to charge different premiums for rural areas than urban areas?

Mr. THORPE. One of the things the State can do is that the State will be allowed to set up with some few limitations the alliances within the State of Oklahoma. So to that extent, depending on the alliance boundaries, there could be a difference.

Mr. SYNAR. I take that as a yes.

Mr. THORPE. Yes.

Mr. SYNAR. What factors will be included in making those variations?

Mr. THORPE. The alliance boundaries would be made by the States. They would be geographical.

Mr. SYNAR. Is age a factor they might take into account?

Mr. THORPE. In drawing the alliance boundaries?

Mr. SYNAR. Right. Property levels?

Mr. THORPE. Certainly the intent is not to segment areas based on expected cost.

Mr. SYNAR. Will the plan designate what factors are taken into account as the caps are set?

Mr. THORPE. No. The premium target, if you will, for the alliance will be determined by the National Health Board.

Mr. SYNAR. Then it is sent to the States and what will the health alliance do?

Mr. THORPE. The health alliance then will be in charge of negotiating with health plans to make sure that the average premium——

Mr. SYNAR. Where I am taking this is that our history with HHS on reimbursement and cost containment would give one in a rural

area great pause. Our ability to continue to provide hospital care as well as providers depends upon what we can get reimbursed. How that cap is applied in rural areas versus urban areas, particularly where rural areas are old and poorer, is critical.

What assurances can I give people in rural Oklahoma that this is not just another way to treat them as second-class citizens and that factors critical to quantity and quality of care in rural America and rural Oklahoma, that the plan will be sensitive to that?

Mr. THORPE. Two things. I don't know demographics of rural Oklahoma that well, but my sense of a lot of rural areas is that there would be a substantial amount of new spending flowing into rural areas because you would have a lot of uninsured individuals who will now have a health insurance card. If you looked at where the change in spending is going to occur, a lot will be in rural States that have a number of uninsured people. So money will be flowing there because we are providing coverage.

Second is that there is an attempt in the legislation to make sure that variations across alliance areas, if you will, will not reflect historical differences in practice patterns; and the Secretary will make a specific set of recommendations with respect to how to, if you will, "filter out" variations in practice patterns across areas.

Mr. SYNAR. So you are not going to freeze in the inequities that presently exist?

Mr. THORPE. No. I believe the Secretary has to report within the next 1 or 2 years to the National Board how variations in targets, if you will, by alliance, could weed out variations due to historical differences in practice patterns.

Mr. SYNAR. There is a generally held feeling by those opposing the plan that universal coverage and cost containment are incompatible goals. In 30 seconds tell me why that is not the case.

Mr. THORPE. It is not that they are incompatible. You can't control growth in spending without universal coverage. You have to have both. No matter how you wanted to control health care costs—whether by regulation, competition or some mix—unless you have everybody covered, that can't happen, largely because you have uncompensated care still sitting in the system which in a competitive market is not viable because you try to compete to avoid uninsured individuals and risk.

To rely on rate schedules to control cost that is problematic because you have uninsured individuals and uncompensated care as well. If you are going to control the growth in health care spending, you have to have universal coverage.

Mr. SYNAR. Thank you.

Mr. WAXMAN. Thank you.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Thorpe, every time that President Clinton makes a speech about his health care plan or the administration puts out a paper on the plan, we hear over and over again about the six guiding principles. One of those principles is choice.

I agree that guaranteeing choice is a fundamental principle and that we shouldn't pass a plan that doesn't provide choice. Clearly, the administration believes that the September 7th draft placed undue restrictions on choice, particularly with regard to fee-for-

service plans. In the draft the alliance was given the authority to limit the number of fee-for-service plans to three, and that restriction appears to have been dropped, but I continue to have serious doubts about the extent of choice provided in the Clinton plan, particularly the choice of more expensive fee-for-service plans that allow freedom to choose any doctor.

When you look at how the plan actually operates, you realize that choice is very limited. For example, let's look at how alliances work. If individuals decide to move to higher cost plans in the second year, if we start at the top of the chart, we see the weighted average premium is determined in year one of the Clinton plan.

Plan A has a premium of $2,000 and two individuals have selected that plan. Plan B has a premium of $3,000 and two individuals have selected that plan. Plan C is the only fee-for-service plan that has submitted a bid to the alliance so the alliance has to accept it in order to provide individuals with a fee-for-service option. It has a premium of $4,000. Again, two individuals have selected that plan.

The weighted average is determined by multiplying the number of individuals in each by the premium amount to arrive at the total amount of the premiums paid to each plan. Then the totals are added to get the total amount of premiums paid to all plans. This number is then divided by the total number of individuals to get the weighted average, in this instance $3,000.

Now let's assume the bottom half of our chart; that a miracle occurs and the plans are so efficient that they don't raise their premiums a cent. However, some of the people in Plan A may decide, or in Plan B, to pay more for a higher quality fee-for-service plan and want to move to Plan C. By one individual from Plan A moving to Plan C and one from Plan B, the weighted average premium automatically increases to $3,500. As we see in the second chart, this is unacceptable. You see the Clinton plan premiums are only allowed to grow at 5.2 percent in the second year of the plan, according to the premium cap; 5.2 percent of $3,000 is $151, which means that the weighted average premium in year 2 can be no more than $3,151. We have a problem, because our weighted average premium achieved by individuals choosing different plans is $3,500. The alliance must now take steps to reduce the level of spending in the system or be in violation of the statutory premium caps.

I want to emphasize that it is at this point that the choice goes out the window because of the interactions between the premium cap and the average weighted premium for the alliance. Even though all plans froze their premiums in the second year, the average weighted premium target has been breached. Now we must go to section 6001 D. That section will automatically reduce the regional alliance inflation update in the next 2 succeeding years for all plans in the alliance.

The statutory formula spreads out the reduction in the inflation update over 2 years. In this example, the inflation update will be reduced to zero for the next 2 years.

Let's recap. In this alliance, because two people shifted to a higher plan, the average weighted premium exceeds its target value in year 2 even though all plans froze their premiums in year 2. This

automatically triggers section 6002 D which then reduces the inflation update for years 3 and 4. Therefore, because of people shifting to higher cost plans, the alliance and its plans are penalized.

This example clearly documents the interaction between the alliance's weighted average premium calculation and premium cap. It appears that when individuals simply exercise their choice of plan, the alliance in its health care plans could be unfairly penalized. Is this the administration's intention?

That is my question. I am sorry it was so brief getting there, but that is the way it goes.

Mr. THORPE. Mr. Bliley, I will try to be briefer. A couple of things. One is that, of course, the analysis you have gone through is highly dependent on several assumptions that you have made, I think none of which in reality would actually occur.

Mr. BLILEY. People wouldn't want to change?

Mr. THORPE. Let me go through them one by one. Point one, the fee-for-service plan, Plan C, as you know may, if it so chooses, relies on a fee schedule that the alliance would develop. We have had substantial discussions among academics within the administration about whether or not the fee-for-service plan would actually be lower in terms of costs than the average cost plan because it could rely on alliances developing a fee schedule. That was a major concern among some individuals who would like to see the HMO's and other plans be less expensive.

Mr. BLILEY. How could a fee-for-service be lower than an HMO?

Mr. THORPE. It depends on where the fee schedule is set. There are several examples of fee-for-service plans that have lower premiums than HMO's. If you look at the evidence, for example, in the RAND health insurance experiment, it shows that using cost-sharing; and if you combined it with rate-setting, which that did not, that HMO's and fee-for-service plans would yield equivalent premiums and equivalent total spending. A lot of it would depend on where the fee schedule was set.

Mr. BLILEY. If we would keep the record open, I would appreciate you sending me the rationale on how you arrived at that, and I hope it arrives sooner than the rationale for the First Lady's because I have been waiting for that since September 28.

[The information follows:]

The fee-for-service plan could charge a lower premium if it required policyholders to pay a larger deductible or more co-payments than paid by those in HMO's.

Mr. THORPE. If I could finish the remainder of the response, you have also constructed a situation where you have, it looks to me like, two-thirds of the individuals switching in 1 year to the very highest-cost plans, spending $1,000, $2,000 more per year. That runs counter to anything I have learned or ever seen in economics.

Mr. BLILEY. One-third, not two-thirds.

Mr. THORPE. So the fact that you have switching like that within a plan, every piece of evidence that we have had from Minnesota, from California, has never shown anything like that. In fact, it has shown the opposite pattern of switching going into lower-cost plans. I think you have put together an example that, in terms of the cost for fee-for-service plans, I don't believe is likely to be the case; and second, that you have a third of the people switching into high-cost plans.

Mr. WYDEN [presiding]. We will hold the record open. The gentleman is correct in saying that this deserves further attention, and we will hold the record open.

[The information follows:]

Typically, persons would seek the less costly plans which would cause the average premium to go down, not up.

Mr. WYDEN. I would like to go back to the matter of the numbers and refer to the charts that you handed out. We totalled it up and it seems that the Medicare savings are about $123 billion, the Medicaid savings $65 billion; that would suggest $189 billion worth of savings in Medicare and Medicaid on the basis of what you calculate today.

On the spending side, the elderly and disabled will receive about $130 billion in drug and long-term care benefits and $25 billion in subsidies for low-income early retirees. This appears to me to add up to about $190 billion in savings and about $155 billion spending on poor and aged and low-income. So it looks to me, on the basis of the charts that you hand out today, that the poor people and the senior citizens are putting about $35 billion into deficit reduction.

Is that analysis correct or is it off base and maybe we are not reading the charts right?

Mr. THORPE. I would be happy to walk through the numbers with you.

Mr. WYDEN. Is it essentially correct?

Mr. THORPE. I don't believe so. If you look at the distribution within our discount pool where our discounts go, I know that three-quarters of the employer-based discounts go to low-wage small firms. If you look at the discounts that we have developed toward employees and non-workers, the bulk of those discounts also go to low-income individuals as well.

We would be happy to provide you a chart showing the distribution of where the discounts go to individuals by income as well as by firm size.

[The information follows:]

A two page chart entitled "Breakdown of Workers According to Subsidy Levels" is provided. The chart shows the distribution of subsidies to employers, the number of employees in categories of size of firm and wage income. It also displays the number of employees by employers' premium payment obligations due to firm size and average annual wage.

Breakdown of Workers According to Subsidy Levels

Percent Distibution	In Regional Alliance — Firm Cap 3.5%	4.4%	5.3%	6.2%	7.1%	7.9%	No Cap	Corporate Alliance	Workers (thousands)
All Workers	5%	3%	3%	4%	4%	16%	45%	19%	116,841
By Firm Size									
Less than 25	23%	10%	9%	12%	10%	5%	31%	0%	26,989
25-99	0	9	9	8	9	17	48	0	16,345
100-499	0	0	0	0	0	44	56	0	18,025
500-999	0	0	0	0	0	38	62	0	7,145
1,000+	0	0	0	0	0	27	73	0	15,734
5,000+	0	0	0	0	0	0	31	69	32,603
By Industry									
Ag/Forestry/Fish	20%	21%	15%	8%	5%	13%	16%	3%	1,938
Mining	0	0	1	1	0	4	59	35	789
Construction	0	1	6	12	13	15	45	7	6,755
Man Durable Goods	0	0	1	2	3	15	46	32	12,531
Man Non Durable Goods	1	1	2	3	4	24	34	30	9,132
Trans/Comm/Public Utilities	0	1	1	2	3	9	51	32	8,547
Wholesale	0	0	1	2	4	10	65	19	4,823
Retail	15	9	5	5	2	19	14	32	19,815
FIRE	0	0	2	4	5	17	47	25	7,754
Bus/Repair	3	4	8	9	8	20	31	18	5,786
Personal Services	35	13	4	3	1	18	6	20	3,649
Ent/Recreation Services	13	13	5	3	1	16	37	12	1,911
Professional Services	4	2	3	3	3	20	62	4	27,572
Public Administration	0	0	0	0	0	0	100	0	5,837
By Coverage									
Single	7%	5%	4%	4%	4%	18%	39%	19%	39,727
Not single	4	3	3	4	3	16	47	19	77,114
By Wage Income									
<15K	11%	6%	5%	5%	4%	18%	34%	16%	41,797
15-25K	4	3	3	5	4	19	44	17	26,411
25-35K	2	2	2	3	4	15	52	20	18,974
35-45K	1	1	1	2	2	13	56	23	12,078
45-55K	1	1	1	2	3	11	54	27	7,614
>55K	1	1	2	2	2	11	56	25	9,966
By Hour Status									
Part time	12%	5%	4%	4%	3%	16%	37%	18%	13,872
Full time	4	3	3	4	4	16	46	20	102,968
By Region									
Northeast	4%	3%	3%	3%	3%	24%	42%	18%	24,097
Midwest	6	3	3	4	3	18	43	20	28,824
South	6	4	4	5	3	14	43	21	29,833
West	5	4	3	4	4	11	51	18	24,087
By Age									
<25	7%	5%	4%	3%	3%	16%	40%	22%	18,182
25-<35	5	4	3	4	4	18	42	20	33,487
35-<45	5	3	3	4	3	16	48	18	31,147
45-<55	5	3	2	4	4	15	48	19	20,517
55+	6	4	4	4	4	17	44	17	13,508

Source: The Urban Institute

Model 106C 16-Dec -93

Distribution of Workers by Average Wage, Firm Size, and Current Offering of Health Insurance

Firm Offers Insurance

Average Pay at Firm	Firm Size Less then 25	25-99	100-499	500-999	1,000-4,999	5,000+ In	5,000+ Out	Total
<12K	2,344	1,850	1,823	714	2,931	946	1,402	12,020
12-<15K	1,111	1074	1,363	418	1,173	466	685	6,290
15-<18K	1136	1,030	1,215	436	1,105	309	581	5,812
18-<21K	1,705	1,153	1,405	559	1,491	496	810	7,619
21-<24K	1,464	1,283	1,648	643	1,844	587	1,085	8,554
24-<28K	1,823	1,973	2,298	948	2,776	733	1,212	11,763
28-<32K	1,080	1,586	2,030	669	2,505	644	1,111	9,625
32-<36K	683	1,183	1,502	628	1,823	516	1,101	7,436
36K+	1,442	1,769	3,061	1,617	8,541	2,615	5,480	24,525

Firm Does Not Offer Insurance

Average Pay at Firm	Firm Size Less then 25	25-99	100-499	500-999	1,000-4,999	5,000+ In	5,000+ Out	Total
<12K	4,556	952	436	122	556	249	308	7,179
12-<15K	1,688	379	222	47	118	49	87	2,590
15-<18K	1,471	301	169	49	80	54	75	2,199
18-<21K	1,832	320	157	46	116	90	99	2,660
21-<24K	1,292	302	131	61	106	94	84	2,070
24-<28K	1,439	489	163	72	160	77	79	2,479
28-<32K	714	311	151	42	89	44	85	1,436
32-<36K	388	195	82	25	67	37	67	861
36K+	820	196	160	52	202	87	211	1,728

Model 106C

Mr. WYDEN. That money goes to firms rather than to employees does it not?

Mr. THORPE. Most of the discounts—there are two places I was suggesting. One is for employers of low-wage individuals. The household discounts are really directed towards individuals who earn under 150 percent of poverty and non-workers. So the bulk of it is focused on people in poverty as well as people below 150 percent of poverty.

Mr. WYDEN. Can you tell us then as precisely as you have today, how much is going for new Medicare and Medicaid spending and how much is going to spending cuts? We have waltzed this one around the mulberry bush again and again but every time I look up it looks to me like poor people and seniors are basically putting a great deal into deficit reduction, and maybe you could tell me otherwise.

Mr. THORPE. Let's take the Medicaid program.

Mr. WYDEN. How about starting with a figure? How much is going for cuts and how much is going for new spending?

Mr. THORPE. The Medicare program, I don't know how much of the home and community based program goes to seniors. I will provide the figures to you.

[The information follows:]

The Department estimates that 71 percent of the 3.1 million persons who are eligible for the new benefit will be over 65 years of age.

Mr. THORPE. I think until we have those, I couldn't complete the circle without those on the Medicare piece. On the low income piece, to me, there are, I believe, unquestionably more benefits going to low-income individuals under this plan than there are savings to the Medicare program because the bulk of our discounts going to households are for low income individuals and non-workers.

Going to the figures under discounts of the $274 billion in discounts that is actually written into the legislation, the bulk of that goes to low income individuals. I would be happy to supply you with the distribution, Mr. Wyden, of where those discounts go by poverty status.

[The information follows:]

The information can be extrapolated from the charts already supplied. The Department will supply, as requested.

Mr. WYDEN. A question on technology. You have stated several times that significant savings will come about as a result of wise use of medical technology. In your view, is it sufficient to bring this new day about simply by providing financial incentives to spend less?

Mr. THORPE. No. I believe it is what happens as a result of restructuring the delivery system, moving away from a unorganized, fragmented fee-for-service system and developing health care networks along many of the models that we have talked about. I think that that structure doesn't inhibit the pace of innovation but it certainly rationalizes its diffusion.

Mr. WYDEN. I will tell you, I think you are missing the boat on technology. When I talk to the big buyers, the insurance companies, the health maintenance organizations and others, they tell me

they can't distinguish one technology from another. They don't have good comparative information.

And we have been talking to some of your folks about the need for this information and they keep saying, well, there is going to be all this additional outcomes research, but I don't see where the massive sum that would be necessary to really get this useful information about technology is going to be coming from. I have given you a proposal to incentivize this through the private sector and look forward to pursuing that with you.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. McMillan.

Mr. MCMILLAN. As I read the numbers, I think you have incrementally more expenditures in Medicare than you have savings and you are going to outline details on that next Monday as I understand.

On Medicaid, it seems to me you are taking basically the cash reimbursement under Medicaid which goes to 100 percent of the level of poverty plus the State subsidies, plus the disproportionate share payments, paying it into reasonable health care alliances and expanding the benefit level up to 150 percent level of poverty, the incremental level of which will be paid by mandates. I don't have a quibble with that. I think that is an appropriate level of the expansion of benefits.

I disagree with the method by which you do it and that is mandates. I think there is another way to do that because it gets to the heart of my major concern about your proposal. If you really believe in competition out there holding down costs, then what is the necessity for caps on premiums?

I can see a cap on the amount the government is willing to pay and reimburse. I think that is very different. That could go to the individual under a system that would maximize competition. What I really fear about your plan is that you consolidate competition and essentially will eliminate it so that the purchasing of health care coverage will be like purchasing a F-15 fighter plane with a top-down, directed program with a fixed price laid on top of it.

And I suppose we will be debating about that central point all through here, because I think there are alternative ways to maximize competition and precisely define government's financial role in a way that effectively gets at the uninsured, and we will talk about that some more.

I wanted to focus on what you have here in administrative costs because that is clearly a major cost element. In your proposal, I think you add an incremental $9 billion over a 5- or 6-year period, which is the Federal administrative cost of running regional alliances. I am not sure whether you show any savings in other programs. Then there is the administrative cost of running the health care alliances which are not reflected here.

And I believe you said in response to a question last week that that would be paid into those alliances by the member people, which is about 88 percent of the population going in. How much is that going to be? What administrative cost factor is implicit in the running of the regional health care alliances?

Mr. THORPE. There are two pieces of that. One is that the health plan limits the administrative costs to 15 percent. The alliance lim-

its the health plan's administrative costs to 15 percent. Of that, approximately 2.5 percent would be administrative costs for running the alliances.

Mr. McMILLAN. That would be about half of the best cost of administering plans that we have seen in the public or the private sector?

Mr. THORPE. Again, the calculation essentially is that the alliance of course does not do all the administrative functions that a health plan does. What we have done in our calculations is look at the administrative functions that the alliances would be performing, many of which are being performed in the market now and the residual administrative functions that would be performed by health plans and we have built both those into the 15 percent.

Mr. McMILLAN. So presumably the administrative costs of plan operators, whether it be an insured plan or a managed plan, are going to be reduced by administrative costs or method savings, the automation of the system, but a big factor would be, would it not, a reduction in the marketing cost of insurance, which would be essentially nonexistent. Is that correct?

Mr. THORPE. There are substantial administrative savings in the insurance market by moving away from the individual sale of insurance and the marketing and underwriting costs associated with selling to small groups. Those underwriting expenses where health plans now go out and take medical histories, and try to select out favorable groups, those administrative expenses would no longer be borne.

Mr. McMILLAN. Isn't that likely to occur in any scenario that very effectively reforms group insurance plans? In other words, if you have got broad access to group insurance, the marketing cost is going to be reduced dramatically?

Mr. THORPE. For some plans, yes, but as a system, no. If you are looking at systemwide administrative costs you have to have universal coverage, and I believe a similar set of insurance reforms that the President has proposed, where you do really have mandatory purchasing pools, not competing voluntary pools, et cetera, so that insurers don't focus on selection and measurement of people's health status but on managing health care.

Mr. McMILLAN. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

First, I would like to say that I appreciate the concerns that have been raised about to the cuts in Medicare and Medicaid, and that potentially additional revenue may be necessary in order to make sure that these cuts are not too onerous on these programs.

Specifically, I assume that we may need to take a stronger look at the taxes on tobacco products in order to generate additional revenue. Coming from a neighboring State to Canada, let me tell you that what is being proposed doesn't match what they are already charging to the north of us and won't totally alleviate the problems that they currently experience with people who come across the border in order to purchase tobacco products in the State of Washington. Potentially you could look to some stronger revenue there to help prevent cuts in Medicare and Medicaid.

Let me move on to the issue about the presently insured Americans who potentially will be paying 30 percent more as it has been related. I would appreciate your comment as to how many would pay more and how much more they would be paying, and, to put it in perspective, what is the effect when we start the change with health care reform as opposed to what it may be after 5, 10, 15 years if we do nothing?

Mr. THORPE. I think the figures that Mr. Panetta discussed last week were that approximately 70 percent of individuals that are currently insured through an employer would spend the same or less and that the remainder would spend a little bit more. I don't have the figures in front of me, but my recollection is that among those that save the money right off the bat, that is in the first year of implementation, that the average yearly savings were about $737. About 15 percent of the American public would save over $1,000 per year.

To get to your second point about what happens over time, it is true that over time that the average increase among those individuals who will spend a little bit more, that average increase shrinks and the average savings rise; so that by the year 2000, the average savings would rise to $1,075 per year and fully 23 percent of the American public would save over $1,000 per year in their health insurance premiums and out-of-pocket spending.

Mr. KREIDLER. It was pointed out to me that that 30 percent number that I used was relative to the total number of individuals in our society right now—30 percent of them would wind up paying more, but they wouldn't pay 30 percent more. I am thinking one step ahead of the next question.

Mr. THORPE. It is 30 percent of the currently privately insured—of the individuals who are insured through an employer.

Mr. KREIDLER. Exactly. I appreciate your response to that. Relative to potentially looking toward tobacco products for increased revenue here, I might point out that in the State of Washington, which had used tobacco taxes to help fund health insurance reform, there was a tax rollback initiative which was heavily funded by the tobacco industry, which was rejected by the people of the State of Washington. That certainly could be viewed as strong support on the part of citizens to look toward tobacco products as a source of revenue.

A major argument against that initiative which failed was that it was being funded by the tobacco industry, which may be an indication that the additional revenue to help make sure that Medicare stays solvent is there for the tapping.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Dr. Thorpe, let me pursue my second round with you. Later we are going to hear from Stuart Altman. Dr. Altman said that in the matter of adjusting premium caps among geographic regions of the country, you had a complicated decision. You could take one of two choices. One would have set the premium caps on the basis of historic spending for health care in each area or premium caps could be based on adjusted national averages.

The first approach seems to run the risk of locking in place current spending levels regardless of the reasons for these differences,

and the second option may not take into account important differences in the population, the resources available to provide care, or the practice patterns of health care professionals.

How does your approach to reflecting geographic and other regional differences balance these important and sensitive issues? Do you believe that areas that require substantial investment to increase services will have enough room to do that, while those areas with excess capacity will have an incentive to become more efficient?

Mr. THORPE. I will try to answer in two parts. First, in areas that have low per capita spending, I believe that what you will see is a relative increase in spending largely because you are going to provide health insurance to individuals. One of the reasons, not the only, but one of several reasons why you will see areas of the country that have low per capita spending is because they have a large incidence of uninsured individuals. In those areas, you are likely to see an initial increase in spending.

Once you have everybody in the system, then the question is how do you make adjustments across areas for the cost of providing health insurance. I think you would want to include at least three factors. One is the fact that more people will now be insured, you want to take that into your calculation of per capita spending.

Second is that since this is based on place of residence, that you want to make sure you can adjust the data by border crossing and other factors like that. And third, you want to look at the cost of providing medical care services. The dilemma is that in the near term, other factors are also likely to be included in this such as the historical variations in practice patterns. I think that the intent here is to try to filter out of those variations across alliances that are solely due to variations in practice patterns that really don't yield defensible increases or changes in health benefits.

So our ability right now to measure it is improving. I don't know if we had to make such a cut today that we could do it as accurately as we would like. The intent certainly is to try to, over time, to make sure that we don't have reflected in these numbers underlying variations in practice patterns that don't represent increments in health.

Mr. WAXMAN. Well, you want to allow those areas where they have low spending to increase their spending, especially if competition involves systems that are going to meet new needs, and sometimes that will mean that they will have to make capital investments in order to compete to have good systems that are going to be attractive.

We will hear later from the insurance industry. They are afraid that health plans may need anywhere from $30 to $90 billion in new capital to build to capacity and information systems that will be required for health reform, but that if you limit their ability to do that, all you are going to do is ration care because they will have to live under a premium cap.

How do you respond to that?

Mr. THORPE. Three ways. First is that I believe in areas that are currently underserved that you are going to see a fairly substantial influx of new revenue.

Mr. WAXMAN. And you would permit that under your proposal?

Mr. THORPE. That would be included because the variations across regions only pertain to the health insurance premiums once everybody has become insured. So you will see big increases in per capita spending, I believe, in underserved areas today that have large incidences of uninsured individuals.

Mr. WAXMAN. How do you deal with an area that is underserved when it is an urban area as opposed to a rural area? If you take Los Angeles, New York, or any big city, you have a lot of people that are insured, you have health care that costs more than other places in the country, and yet in the core, you have a lot of people without insurance coverage who are going to need resources?

Mr. THORPE. Facilities that have been traditionally most strapped, New York City, for example, will have a fairly substantial influx of new private funding. Their Medicaid population will now receive coverage through the alliance and private health plans. The uninsured they take care of. I think it is those facilities in a city like New York that are underserved that are going to get the biggest increases in revenue.

The other two points I make on the capitalization side are first, as I pointed out earlier, the cost of providing medical care in this system, whether it is through a health insurer or through a provider as well as to an individual, which is even more difficult to measure, is going to fall. Although you have slower growth of revenue, which is not as slow as some of us I think are portraying, we would have a substantial influx of new revenue flowing into this system. Just because you have a slower growth of revenue doesn't necessarily mean that the net income for investment is lower, because the cost of providing care is lower.

Third is that in the allowed premiums in the insurance administrative loads that we have calculated, that 15 percent that allows for capitalization for new plants and equipment. So we made a calculation of that and put it in our allowable administrative load.

Mr. WAXMAN. I very much appreciate your answers to all the questions we have posed to you. I know there will be other questions. This is not the end of our discussion with you and others in the administration. I appreciate your being here. If there are questions that members may wish to submit in writing to you, we would appreciate your responding in writing for the record.

Mr. THORPE. Thank you, Mr. Chairman. I know there were several outstanding requests that I didn't perhaps fully articulate that I would be happy, once I have time to reflect on it, to work with you and staff and provide you as detailed and quick answers as I could.

Mr. WAXMAN. Thank you very much.

Our first panel of witnesses consists of representatives to two advisory bodies to the Congress and to the Secretary of Health and Human Services on Medicare payment policies to hospitals and doctors. Dr. Stuart Altman is chairman of the Prospective Payment Assessment Commission, and Dr. Paul Ginsberg is the executive director of the Physician Payment Review Commission. Both are well known to this subcommittee from their previous appearances.

I would like to welcome the two of you to our hearing today. Your prepared statements will be in the record without objection. We

would like to ask you to limit your oral presentation to no more than 5 minutes. Dr. Ginsberg, we will start with you.

STATEMENTS OF PAUL B. GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION, AND STUART H. ALTMAN, CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. GINSBURG. Thank you, Mr. Chairman.

Two approaches to cost containment have emerged over the past few years. One draws on the experience of the Medicare program in setting payment rates for hospital and physician services and applies them to private payers. The other emphasizes the use of market forces to stimulate the development of health plans that integrate financing and delivery of care. The administration's proposal incorporates both approaches, tying them together with a system of premium limits to guarantee that enough savings are achieved.

The Commission has analyzed the potential of these approaches to contain costs for some time, devoting particular attention to how to integrate them. We believe that combining elements of rate setting and managed competition is feasible. Although it has not yet developed recommendations on the President's proposal or the other leading proposals, the Commission is pleased to share with you its analysis to date.

Growth in health care spending must be slowed to a rate that is affordable. Whether managed competition or provider rate setting gets prime emphasis, additional cost containment policies are critical to reducing growth and spending sufficiently. These include controlling the number and specialty mix of physicians in training, a national data strategy, outcomes research and the development of practice guidelines and medical malpractice reform.

A major challenge to the use of expenditure limits is the fact that we have so much variation in spending per capita across the country. With the development of additional knowledge about effective medical practice and application of substantial pressures for cost containment, these differences are likely to diminish over time.

It would be wise to initiate a budgeting system on the basis of historical patterns of spending. This would avoid major disruption in some areas. But concrete plans need to be made to permit those areas with relatively low spending per capita to grow more rapidly than those with high spending. In writing legislation to reform health care, you will need to decide whether to specify a process for future decisionmaking on this as the administration has proposed or to include a formula for reducing these differences over time in the legislation.

The Commission's report on expenditure limits discusses this issue in depth. The application of premium limits to health plans raises parallel issues. Rather than apply a uniform limit throughout a region, the administration would, after the first year, apply a plan specific limit based on the plan's premium during the base year. This has advantages of minimizing initial disruption of health plans and less dependence on risk adjustment mechanisms that are not yet well developed.

But over time problems with this approach become more serious. Those plans that have started off as the most efficient will be constrained the most and will be impeded in expanding to increase their market share. Basing limits on premiums during a base period will become increasingly inequitable over time. The Commission is developing options in which premium limits transition from the plan specific to a uniform limit for the region over time.

The administration has proposed a suitable method to combine provider rate setting with competition among organized plans. Fee schedules would be negotiated between regional alliances and providers and applied to out of network use. Individual health plans would be free to contract with network providers in any way that is mutually agreeable. This precludes the need to categorize health plans, all of which would be subject to premium limits.

Thank you.

Mr. WAXMAN. Thank you very much, Dr. Ginsberg.

[Testimony resumes on p. 187.]

[The prepared statement of Mr. Ginsburg follows:]

Paul B. Ginsburg, Ph.D.
Executive Director
PHYSICIAN PAYMENT REVIEW COMMISSION

As the Congress considers options for health care reform, the opportunity to expand access and maintain an affordable, high quality system depends on designing policies that will result in effective cost containment. Two approaches to cost containment in health care have emerged over the past few years. One draws on the experience of the Medicare program in developing mechanisms for setting payment rates for hospital and physicians' services and applies it to private payers. The other emphasizes the ability of market pressures to motivate cost containment by health plans in a competitive marketplace. The Administration's proposal starts from this second approach by looking for market pressures to achieve savings while also incorporating a system of premium limits and fee schedules to serve as a backup to guarantee that savings are achieved.

The Physician Payment Review Commission has over the past two years analyzed ways that regulatory approaches, in which expenditure limits are enforced through provider rate setting or premium limits, can be combined with market-based approaches. In addition to consideration of a range of technical issues, it has considered the question of how regulatory tools might be designed to avoid impeding the ability of practitioners, including those in organized systems of care, to make needed changes in medical practice.

In July, the Commission submitted a report to Congress, *Expenditure Limits: Design and Implementation Issues*, that considered a number of issues that might arise in setting up a global-budgeting system, especially as it relates to physician and other professional health care services. That report focused specifically on the enforcement of expenditure limits through rate setting, the applicability of rate setting to organized systems of care, and the issues involved in assigning the limits to states.

Currently the Commission is analyzing a variety of issues involved in health system reform:

- expenditure limits enforced through premium limits
- graduate medical education
- risk adjustment

- medical malpractice reform
- fee schedules for private payers
- health alliances: structure, roles, geography
- quality assurance
- coverage decisions for new services and technologies
- access for the underserved
- regional and national data needs
- increased managed-care options for Medicare beneficiaries
- the Administration's proposed Medicare cuts

While recommendations have not yet been made, the Commission is happy to share with the Committee our analysis to date of these issues. The Commission will meet in December and January to consider recommendations on these issues and will be communicating them to the Congress on a regular basis through testimony and memoranda, as well as through submission of its annual report at the end of March.

The Commission approaches these tasks drawing on its experience in a number of related areas. It proposed Medicare's resource-based fee schedule and now advises the Congress on refining and updating it, on broadening its applicability to private payers and other public payers, and on monitoring changes in beneficiaries' use of services and access to care. It proposed an expenditure target for Medicare physician payment, which was enacted as the Medicare Volume Performance Standard (VPS) system, and it has recommended various revisions to this mechanism for updating the fee schedule conversion factor on the basis of comparing expenditure growth with a previously established standard.

This statement addresses three broad issues relevant to this hearing. First, it considers the ability of reform strategies in general to achieve overall cost-containment goals held by many policymakers, while identifying some complementary policies that might make these goals easier to achieve. Second, it looks at a number of policy and technical issues that arise in setting expenditure limits, particularly those that arise when assigning targets to states or substate

regions. Finally, it addresses key strategies for enforcing expenditure limits. In particular, it looks at the roles that rate setting and premium limits might play in achieving cost-containment goals.

ACHIEVING COST-CONTAINMENT GOALS

Reform proponents generally agree on the need for substantial cost containment. Furthermore, many would agree both that considerable one-time savings can be obtained from the system and that the long-term rate of growth in spending can be slowed. The disagreements are over, first, the types of policy tools that might enable the system to achieve these goals and, second, the speed with which such savings might be achieved and whether they are sustainable.

Some reforms, such as those to restructure the insurance market, may lead to immediate administrative savings because insurers do not need to market individually to small firms. They may also contribute to longer-term savings as people switch over time to lower-cost plans. In addition, increased movement into managed-care environments and the strengthening of either market or regulatory forces may help the system achieve some of the savings and productivity gains that are now seen in some HMOs and in some parts of the country.

A system that combines expenditure limits with these structural reforms will provide a backstop to ensure that savings are achieved. The success of either approach, however, will be enhanced by complementary policies that provide tools for health plans and providers to control costs. These policies decrease the pressures that fuel cost increases, thereby reducing the degree of dependence on expenditure limits to meet cost-containment goals. The Commission has previously recommended to the Congress several such policies that would facilitate achievement of both short-term and long-term goals.

- Controlling the number and specialty mix of physicians may help to reduce supply-driven pressures to increase use of services.

- A national data strategy could provide the basis for achieving certain administrative efficiencies as well as a stronger database for supporting both the use of profiling by health plans and other entities and research on the effectiveness of medical interventions.

- Practice guidelines and expanded funding for research on medical outcomes could provide information to physicians to enable them to practice more effectively and efficiently.

- Medical malpractice reform could save premium dollars and reduce defensive medicine.

With these various policies as a foundation, the next question is how to set achievable growth targets. The Administration proposal calls first for the achievement of short-term savings to bring the rate of growth of health costs down to the level of inflation over four years. It would then leave determination of the long-term growth target (after 1999) to the Congress but would create a default growth rate equal to population growth plus inflation plus growth in real income.

The Commission agrees that it is both unrealistic and undesirable to attempt to sustain a long-term growth rate that allows only increases to cover inflation. In making its annual recommendations for the Medicare Volume Performance Standard, the Commission adopted a goal of reducing expenditure growth in physicians' services to a level that reflects increases in the number of Medicare beneficiaries, inflation, and the national rate of growth in real income per capita. In the short term, the challenge is whether a tighter standard might be set in order to

help purchasers, taxpayers, and consumers capture the types of immediate savings that some believe can be achieved.

SETTING EXPENDITURE LIMITS FOR STATES AND ALLIANCES

In a system that would set limits at a state or substate level, policymakers are confronted with the need to devise a strategy for addressing the substantial variations in historical rates of per-capita expenditures around the country -- the twofold spreads that currently exist from the highest-spending states to the lowest. They would have to decide whether these different levels are the right starting points for requiring states or alliances to control costs or whether states or alliances would be required to meet a common expenditure limit after a period of years.

The Administration proposal reflects a reasonable conclusion that -- in the short term -- the only viable strategy is to hold each state or alliance accountable to its own historical baseline. That proposal calls on the national board to send recommendations to the Congress for reducing the variations among states in the future.

The use of separate historical baselines to set targets for each state is attractive because it does not impose unrealistic requirements on states to meet a common target in the first few years. Regional variations in the practice of medicine are substantial, and this approach incorporates some of the differences between states -- in input prices, demographic makeup of the population, and morbidity -- without the need to measure them accurately. It also recognizes that other differences, such as excess capacity and the provision of inappropriate care, cannot easily be changed in a short time.

The use of historical baselines, however, creates several technical challenges. First is the availability of data from which to create baselines. Newly published data from the Health Care Financing Administration (HCFA) provide a starting point for establishing baselines for states. Additional data, however, would be needed to set baselines for alliance regions. Even if alliance regions follow the lines of metropolitan statistical areas (MSAs) or counties, aggregate spending data are not commonly available for these entities. Setting accurate historical baseline targets for these regions is likely to be a difficult task. Preliminary analysis of Medicare data by the Commission suggests that variations among alliances (if defined as MSAs) are at least as great as those among states. Further research is needed to understand better the variations across states and regions.

A second challenge is the set of adjustments necessary for HCFA's estimates of spending to serve as targets. In particular, these data are provider-based, not person-based. Thus, any time a state's residents cross a state border to receive services, those services are counted toward the state where the provider is located. Second, these estimates would have to be adjusted for use in setting targets to account for those population groups that would not be included under the alliance system (for example, Medicare beneficiaries and employees in large corporations). Third, cost sharing is considered off budget since it is not included in premiums; accordingly, targets would have to be decreased to allow for the estimated proportion of spending that would be paid out of pocket by consumers in the form of cost sharing. Finally, targets would have to be increased to cover the increased utilization that would occur as a result of providing the standard national benefit package to all Americans.

The Commission has done a preliminary analysis of the effects of two of these adjustments: those for border crossing and for increased utilization by the uninsured. This analysis shows the potential for large shifts in state targets as well as some reduction in state variations. Eight states and the District of Columbia, for example, would find their targets adjusted by 10 percent

or more. Further research by the Commission and by HCFA to calibrate these and other adjustments is already under way.

Generally, to the extent that historical baselines are not set accurately, budget pressures on different states and regions and on the plans offered in those areas would become inequitable. Such an imbalance would create the need for mid-course corrections on a budget-neutral basis or could lead to political pressures for a loosening of targets in some areas.

The use of separate historical baselines also has the disadvantage of locking into place various inequities among states. Consider two types of low-spending states: (1) one that has already achieved greater efficiencies in its health system due to state-level reforms or to private-sector developments and (2) one that currently lacks the capacity to provide access to services for its insured population. In the first case, the budgeting process might penalize the state for its success in reducing the amount of unnecessary and inappropriate services provided to its citizens. Health plans within the state would have little or no margin to adopt new technologies or otherwise to expand capacity in contrast to a state with a higher historical volume of services. In the second case, the budgeting process would constrain the state's ability to expand access to its underserved population because the budget locks in the historically low level of services. Poor access for uninsured populations would be accounted for in revising historical baselines to set the initial targets, but there is no basis for making adjustments for poor access to already insured populations.

The second strategy for setting targets entails basing each state's target on an overall national target, making adjustments only for certain uncontrollable differences. These are factors that may drive state variations but cannot be controlled by the state, even in the long term. They might include differences between a given state and the national average in (1) input prices, such

as local wage rates and office rents; (2) demography, such as age distribution; and (3) health status and epidemiological factors.

The advantage of this strategy is that it places all states on the same terms and avoids penalizing states that have already achieved efficiencies or that need to increase services to underserved populations. It might also relieve some of the data needs, since accurate historical baselines would not be needed for each state or alliance region.

Although this approach might make sense in the long term, its main drawback lies in the substantial differences that exist currently. Preliminary analysis by the Commission suggests that it is unlikely that current variations in spending by state could be explained by the types of adjustments listed above. Experts believe that much of the state variation results from differences in practice patterns and utilization levels for underserved populations, which in turn reflect variations in income and prevailing opinions about best practices. Factors such as system capacity (e.g., number of physicians or number of hospital beds) that appear to drive levels of utilization can be changed, but such changes may take many years to accomplish.

STRATEGIES FOR ENFORCING EXPENDITURE LIMITS

Once a goal or target for expenditures is established, a mechanism must be selected for enforcing compliance with the target. The two principal mechanisms envisioned for enforcing expenditure limits in the U.S. system are rate setting and premium limits. Most likely, some combination of the two approaches should be used.

Rate Setting

Rate setting involves the translation of an expenditure limit into a maximum allowable charge for any particular service. In essence, a physician or other provider would not be permitted to charge more for a service than the rate set by the government. This rate could be determined by (1) structured negotiation, (2) an established formula, (3) a policy decision by either the Congress or a national health board, or (4) some combination of the above.

The Commission has considerable experience with this approach to cost containment in the Medicare program and believes that, where rate-setting approaches are built into health system reform, many of Medicare's policies would be applicable. For example, in its July report on expenditure limits, the Commission concluded that, if rate setting is used to enforce expenditure limits, a uniformly applied resource-based relative value scale such as Medicare's should be the basic payment methodology for paying for all professional services. This same conclusion might be applied as well to the adoption of fee schedules by health alliances.

In a system of rate setting, a mechanism for addressing the volume of services must be incorporated to ensure that targets are met. Under Medicare physician payment reform, for example, the Congress chose to set volume targets through the VPS system. This reconciliation of actual spending with the target serves to ensure that budget targets are met and places a collective incentive on physicians to control the volume of services. As such, it was seen by the Commission as a critical component of the strategy for physician payment reform; a similar mechanism should play an important role in applying expenditure limits to total health spending. In its July report, the Commission concluded that, if rate setting is used to enforce expenditure limits, physician payment rates should be updated with a default formula that adjusts for prior-year spending, and physicians should share the bonuses and penalties for changes in the

volume of hospital admissions, laboratory tests, prescription drugs, and certain other types of services that are generally ordered by physicians.

Premium Limits

The premium-limit approach to enforcing expenditure limits typically places the focus of cost containment on health plans. Each plan would be responsible for determining how to meet that overall limit. This approach has the advantage of granting considerable flexibility to plans in finding the best ways to modify practice patterns and contain costs. It also avoids the problem that rate setting is not easily applied to plans that contract with providers on the basis of units of payment other than fee for service.

The Commission has identified three options for implementing premium limits under health system reform. The first option, as included in the Administration proposal for all but the first year, would place limits on the rate of growth of plan premiums in those alliances where overall targets were not met. An alternative is to limit the level of premiums rather than the rate of growth. A third option would be to make a slow transition from limits based on growth to limits based on levels.

The proposal to limit the rate of increase in premiums has some merits. First, it gives plans a stable planning environment, because they know they would not be assessed if they contain their own premium growth to the target rate. Second, testing each plan relative to its own baseline maintains pricing pressure on all plans, not just the most expensive plans, and so might generate higher levels of savings than alternatives that focus on just the high-cost plans. Third, if risk adjustment remains relatively crude during the early years under the new system and if the patterns of risk selection across plans persist, then grandfathering the existing premium differentials is a "back door" approach to adjusting for biased selection in the market. Finally,

if we expect fee-for-service plans to charge high premiums, this approach would tend to limit the disruption that might occur if many of these plans were to be forced out of business quickly.

This approach may also have a number of significant drawbacks. First and foremost, this process is likely to put the greatest financial stress on the most efficient plans, assuming these plans price themselves initially at a level that reflects that efficiency. Inefficient plans could reduce waste to meet stringent budget targets, but efficient plans would not have that option. Second, premium limits based on rates of growth could potentially put nearly all plans under financial stress simultaneously if targets are set at a level that plans find difficult to meet. Third, pressures from using premium limits would be quite different from those arising from competition. Whereas competition should cause individuals to switch to lower-cost plans, these plans may find it no easier than higher-cost plans to generate the surplus they need to expand capacity and gain market share. Finally, the premium limits under this approach could encourage high initial bids in the first year the system is in place. The incentive to bid near costs to avoid loss of market share would be tempered by the incentive to increase the bid to provide slack for the future. It seems generally unfair to base caps over a period of years on the premium charged by the plan in a single year.

An alternative approach to premium limits would assess plans based on the absolute level of their premiums. Under one version of this approach, every plan whose premium was above the average would be assessed as much as necessary to bring the average down to the target for that particular alliance. Such a system generally reverses the incentives created by the first alternative. Where the rate-of-growth approach would distribute the budget pressures across all plans, the premium-level approach concentrates the pressure on the highest-cost plans. Lower-cost plans would face only market pressure to constrain costs. The premium-level approach also allows a more traditional approach to submitting bids, where a plan would have to balance

increased revenue per person against loss of enrollment. It would have the disadvantage of raising the level of accuracy needed from a system of risk adjustment.

These two approaches could be combined by phasing out first-year premium differentials over time. This would grandfather these premium levels only temporarily, softening but not preventing the transition to caps based solely on the level of premiums. To do this, two sets of assessments would be calculated and then combined through some type of weighted average. The principal advantage of this system is that it would provide a transition period to allow improvements in the risk-adjustment formula, to allow competition to begin placing pricing pressure on plans, and to allow plans to improve their efficiency.

Combining Rate Setting and Premium Limits

Regardless of whether rate setting or premium limits is selected as the primary method for enforcing expenditure limits, the Commission believes that each strategy could play an important role in achieving the cost-containment goals desired by advocates of health-system reform. This section looks first at two ways that rate setting could support a system of premium limits. The two approaches assume that fee schedules would be established under constraints imposed by the budget but differ in the way they interact with the budget limits. This section concludes with consideration of a model for creating a parallel system of rate setting and premium limits.

The first approach for setting provider payment rates to support premium limits involves setting the fee schedule's conversion factor at a level designed to allow plans with fee-for-service components to meet budget targets. Whether through provider negotiations or by the decision of a state or alliance, the conversion factor would be updated annually to reflect the budget target for a particular region. The Administration proposal envisions the establishment of fee schedules by each alliance, although it does not explicitly link them to the budgeting process.

This approach creates a link between the fee schedule and budget targets in a way that could help guide the alliance or state in negotiations with providers. It also addresses the difficulties faced by fee-for-service plans without provider contracts in meeting budget targets. The fee schedule, in combination with utilization review and other measures aimed at controlling volume, would help these plans be competitive with others that can use provider contracts to contain costs. This same feature could also be viewed as the principal drawback of this approach. Plans that felt they were operating efficiently and with limited profits would complain that they lacked the tools to meet a tight premium cap.

The second approach modifies the first approach and addresses the concerns of fee-for-service plans by invoking prospective assessments on providers where plan premiums are subjected to a cap. Drawn from the Administration proposal, this approach would prospectively reduce provider payments below the fee schedule in those plans whose premiums are subject to an assessment because they force the alliance out of compliance with its budget target. Assessed plans would pay providers at a discounted rate, for example, at 95 percent of the fee schedule amount. Network-based plans would have to include language in their provider contracts allowing them to pay at a discounted rate.

This approach has the advantage that fee-for-service plans subject to an assessment would be provided a means by which they can come into compliance. On the other hand, this option might have the effect of absolving plans of responsibility for failing to meet their budget target. By passing the assessment on to providers, plans would have diminished incentives to find savings through reductions in either administrative costs or inappropriate care (through utilization review or other techniques) and could in effect lock in profits by passing the effect of a premium reduction on to the providers.

The third option calls for premium limits to apply to some plans and rate setting to others. Specifically, premium limits would be applied to those plans not primarily dependent on fee-for-service payment. This option would have the advantage of using the enforcement method that is most suited to each sector of the health care market. Managed-care plans, which have the contracts with providers that should give them the ability to control prices and the management tools that should allow them to control volume, would be judged by their overall success in controlling premiums. Fee-for-service plans, which generally lack provider contracts and have weaker management tools, would have the assistance of external controls on prices. The major drawback in this approach is the need to define the sectors of the health care market -- that is, which plans are categorized as managed care and which as fee-for-service. For example, how would a dual-option plan that uses capitation within a network of providers but employs fee-for-service for out-of-network use be categorized? One additional issue under this option is whether it would be difficult to calibrate the two budgeting mechanisms so that both sectors operate on a level playing field.

Mr. WAXMAN. Dr. Altman.

STATEMENT OF STUART H. ALTMAN

Mr. ALTMAN. Thank you, Mr. Chairman.

As you pointed out, I am here this morning as the chairman of the Prospective Payment Assessment Commission, and our mandate from the Congress is to focus on facilities and particularly health facilities paid by Medicare which include hospitals, nursing homes, renal centers and the like. In that context, we have been asked by several committees of the Congress to look at the issue of global budgeting and premium caps. I would like to talk this morning about some of our findings and to perhaps put them in a little broader context.

First, the issue of premium controls which the President has put into his plan. We have not as a commission taken a position on that one way or the other, but I think it is fair to say that even the strongest advocates for managed care and managed competition do not believe that the marketplace alone can generate the kinds of savings you are talking about in the plan.

Now, if you decide as the Congress that you want those savings, I think the evidence is overwhelmingly that you will need controls beyond the marketplace. I am not saying you should get those savings, but if you want them, and then you face one of three ways of doing it. You can use old garden-variety price controls, you can use budgeting controls as they do in other countries, or you can adopt the method that the President has used, premium controls.

Price controls can be effective for short periods of time, but what we have learned, and it is in our studies, is much of the increases in spending in this country in health care are being generated by increases in volume. Price controls don't do a very good job on volume controls. Budget controls have been used by other countries and they have been effective, if you define effective as controlling spending, but they have also developed a lot of rigidities in their health systems.

They are not nearly as flexible as ours. Their lengths of stay are much longer in hospitals, they put more people in hospitals. They just don't have the kind of innovativeness in these countries—Canada, Germany, Italy, Netherlands, Great Britain—as we do. Therefore, if you want flexibility and you want controls, I think the premium approach—this is my own opinion—we did not vote on this—makes the best sense. But that doesn't mean that it is going to come easy. There are many decisions that have to be made in terms of how to allocate it. My colleague, Dr. Ginsberg, laid them out.

We looked at and are studying the allocation of spending by State. As you are beginning to see in the newspapers and the like, we spend per capita quite different amounts in different States. We will be presenting to Congress shortly a detailed analysis of State spending in health care. Under any scenario that you want to think about, changes in that allocation would need to be made. As the chairman has pointed out, how they are made will have significant political implications on how it goes on.

One of the areas I would like to close with is the area that we are most concerned about and responsible for, which is the Medi-

care program and its spending. Several of you in previous discussions have raised this issue.

Over the last 10 years, the DRG-PPS system has been quite effective in controlling governmental spending for hospitals. The rate of growth in the hospital side for Medicare is far lower than for other segments. We have not, however, seen any repercussions from the hospital industry or others as a result of these tight controls, and yet hospitals continue to raise their costs much above the prices that in fact Medicare is paying.

On average, in 1991, hospitals received 88 cents for every dollar they spent for Medicare recipients, and there are many hospitals in this country that are getting 20 cents per dollar less than they are spending. How can we not see a backlash?

The reason is now the famous cost shifting. Hospitals have been able to shift to those payers who have been willing to pay a higher amount of money. What is going to happen, and this is the big if—we do not know what will happen in our system when you impose very tight Medicare spending cuts and yet prevent the cost shifting from going on. Cost shifting, in a way, is a hidden tax and, therefore, the President is appropriate in trying to cut it down. But nobody can tell you based on our past experience exactly how that is going to play out. That doesn't mean one shouldn't do it, but one should not quickly do it without recognizing the implications. So we provide some cautionary signals. If you are going to make sizable cuts in the Medicare program in terms of cutbacks and put on restrictions the implications for the Medicare program are questionable.

Thank you very much.

[Testimony resumes on p. 203.]

[The prepared statement of Mr. Altman follows:]

Stuart H. Altman, Ph.D.
Chairman
Prospective Payment Assessment Commission

Good Morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied this morning by Stuart Guterman, Deputy Executive Director of ProPAC. During my testimony, I will refer to a chart that is appended to the end of my written testimony.

I am pleased to be here to discuss the cost-containment aspects of President Clinton's health care reform proposal. For the past ten years, the Commission has been providing Congress with analyses and recommendations concerning hospitals and other facilities, with special emphasis on Medicare payment policies and the Medicaid program. The Commission also recently submitted a report on the design and implementation of a global budgeting system. This morning, I would like to discuss several issues relating to the President's health care reform plan; specifically, I would like to discuss the proposal to cap the growth in private insurance premiums, and the cost-saving measures proposed for the Medicare program.

PREMIUM CAPS

As you know, Mr. Chairman, the President's proposal is based on the managed competition model, in which people will obtain health insurance coverage through regional alliances that will negotiate with health plans that provide health services. Under this proposal, the escalation of health care costs would be constrained through market forces as health plans compete for patients on the basis of quality and costs. The President also has proposed other cost saving measures, such as administrative and paperwork reforms, as well as malpractice and antitrust reform initiatives.

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The cost-containment "backstop" in the President's plan is a provision to limit health care spending by placing a cap on the growth in private insurance premiums. Under the proposal, a National Health Board would establish a national per capita baseline premium target based on per capita health care expenditures for a comprehensive benefits package; this target would be updated annually. The national target would then be differentially allocated to the regional alliances on the basis of population and other factors. The alliances, in turn, would negotiate a premium amount for each plan in their area.

As I will describe further in a few moments, spending for inpatient hospital care has been growing more slowly than spending for other types of providers (health sectors). A premium cap approach to cost control is not sector-specific; that is, it does not set limits separately for each type of provider. While this approach has the flexibility of allowing each health plan to determine spending growth for each sector, it also could result in payments for inpatient hospital care growing even more slowly than the level of the cap, while spending in other sectors grows more rapidly.

ProPAC has examined the various issues related to constraining the growth in health care expenditures, including premium limits. This past July, we submitted a report that discussed the issues involved in designing and implementing a global budget for health care expenditures. As we indicated in that report, limiting health care expenditures relative to the currently forecasted rise in health spending would represent a significant undertaking for the U.S. It also would have important consequences for hospitals and other facilities, as well as the patients they serve.

Establishing a national baseline target and allocating that target to states or regions requires a complex set of decisions. In addition, these decisions would have a substantial impact on the distribution of available funds to health care providers. I would like to discuss several of these issues in a bit more detail.

Facility Spending

I am going to limit my comments this morning to spending for facility services, including inpatient and outpatient hospital services, and skilled nursing facility and home health services. The need to restrain health care expenditures is clear. Spending for these services has risen almost four-fold since 1980, from $123 billion to an estimated $433 billion in 1993. Under current policies, these expenditures are projected to increase to $789 billion by the year 2000, at an average annual rate of 9 percent.

The President proposes to limit the annual growth in the average insurance premium to a national inflation factor based on the Consumer Price Index (CPI). For 1996, premium increases would be limited to the percentage increase in CPI plus 1.5 percentage points. The allowable increases above CPI would be reduced over subsequent years such that by 1999, premium growth would equal CPI growth. For the year 2000 and beyond, the per capita premium would be allowed to grow one percent faster than the increases in CPI plus population plus real gross domestic product (GDP) unless Congress approves another rate.

The growth in health care spending would be considerably slowed under the President's proposal compared to current projections. While we have not estimated the reductions in facility spending under the proposal, we believe that over the first few years they would be similar to what would be achieved if spending were limited to the growth in GDP. We believe a GDP growth target could reduce spending for hospital and other facility services by almost 15 percent, which equals $374 billion over the five year period from 1994 to 1998. A CPI target would result in even greater spending reductions than a GDP target thereafter. A CPI target, however, would not allow any growth in real (inflation-adjusted) per capita spending for health care. It should be understood, Mr. Chairman, that a CPI target would create a tighter spending control system than that of any other nation.

I would like to emphasize, Mr. Chairman, that these estimates assume that any spending limits will be 100 percent effective. In fact, however, they are not likely to be fully achieved. In addition, these estimates do not account for the shifts in spending across sites of care that are likely to occur as a result of the President's proposal. Since spending for health care services is growing at very different rates across types of providers, the decisions by plans that determine these shifts in spending allocations will be critically important.

I now would like to describe the two major factors--price and volume increases--that account for the differential growth in expenditures across provider sectors and that may influence the allocation of the premium limits to hospitals and other facilities.

The Roles of Price and Volume in Limiting Spending Increases

Health care spending is growing rapidly because of increases in the price of hospital admissions and the other individual units of service furnished. An equally important factor, however, is the continuing increase in the volume of services provided per capita. To control health spending, reductions must occur in the rate of growth of price, volume, or both. We examined the relationship between the price and volume of health services to better understand how facility spending growth could be constrained.

To illustrate the impact on price and volume of imposing spending limits, ProPAC estimated the price and volume reductions that would be needed to limit spending increases to the rate of GDP growth by all payers in three health sectors: hospital inpatient, hospital outpatient, and nursing facility. The spending growth rate that we used in this analysis is similar to the limits in the President's proposal through 1999. Specifically, we calculated the price increases that would be necessary to meet the spending target if the volume of services grew at forecasted levels. We also calculated the price increases that would be necessary to meet the target if volume growth were restricted to the increase in population plus the effects of aging. If providers continue to increase the volume of services at current rates, there would be little room left for increases in the payment for each service. On the other hand, if the volume growth of services furnished can be slowed, then larger per service payment increases are possible. I would like to briefly explain our results, as shown in Chart 1.

Meeting spending targets would be easiest to accomplish in the hospital inpatient sector, but only if the share of spending for inpatient care remains constant. If hospital inpatient volume grew as forecasted, hospital payments could increase 5.7 percent per year over the next several years, which is higher than both CPI and the hospital market basket, a sector-specific estimate of expected increases in prices for goods and services used by hospitals. This is because hospital volume (as measured by inpatient days) has been steadily declining, allowing payment increases to constitute all of the targeted spending growth. This annual increase in payments, however, is less than the annual increases currently forecasted. Health plans also have the flexibility to allocate a larger share of the premiums to other sectors. If they do, as is likely, hospital payments will increase even less than 5.7 percent a year.

The story is much different in the hospital outpatient setting, because the volume of services has been increasing rapidly and, consequently, is a major contributor to spending growth. Allowing the volume of hospital outpatient services to grow as projected over the next five years would require that prices be reduced almost one percent each year. Restraining volume growth to increases in the population plus aging would permit prices to grow about 5 percent annually; this result would require, however, a substantial decrease in the volume of services currently provided. As you can see, reducing expenditures for hospital outpatient services to these target levels could have a large impact on the volume of services furnished to individual patients, hospital revenue per service, or both. The situation is similar for home health services.

Volume plays a lesser role in spending growth for nursing facility services compared to hospital outpatient services; under spending limits, however, payments per day would have to increase much more slowly than they do currently if the volume of services continues to grow at current levels. In addition, because nursing facility service volume is driven largely by an aging population, the ability to reduce volume growth is limited.

Again, Mr. Chairman, this analysis does not reflect the spending shifts across sites of care that are likely to occur as a result of the President's proposal. It is not possible to estimate how the spending shifts across providers would play out because these decisions would be made by the proposed health plans in each area. You can anticipate, however, that major shifts will occur. This analysis also demonstrates that changes in either the volume of or per unit payments for health care services, or both, must dramatically change in order to slow the growth of health care spending in this country. Spending reductions mean hospitals and other providers will have less available revenue and will have to control their costs. In response, some providers may go out of business and others will dramatically change how they do business. It will be necessary, therefore, to carefully monitor the effects these changes may have on access to quality care.

Allocating Premium Targets

Mr. Chairman, I now would like to turn to another important issue that could affect quality of care. This is the method the President proposes to allocate premium

target limits across geographic areas. Under the President's plan, the national average premium in the first year would be allocated to the regional alliances and updated annually by region-specific inflation factors. For the initial year, the premium target would be based on the national target and adjusted to take into account state per capita health care spending patterns, premium variations, rates of uninsurance and underinsurance, Medicare program spending variations, and other factors. In succeeding years, the inflation factor would be adjusted to reflect changes in the health status and demographic and socio-economic characteristics of the population served by the regional alliance. In both the initial and subsequent years, however, the weighted average of all the regional alliance inflation factors would equal the national target; in other words, the allocation would be budget neutral. This provision is intended to ensure that the spending limits are met. Enforcing strict spending limits, however, also increases the need to make sure that the adjustments the President proposes result in appropriate spending distributions across states. Before I discuss this further, I would like to note one other topic that is critically important.

Each alliance is expected to negotiate with health plans to determine the premium amounts that comply, in the aggregate, with the alliance target. Since individual health plans are likely to enroll different mixes of patients--in terms of social, economic, and health status characteristics--it is critical that the health plan premiums be adjusted to reflect each plan's mix of subscribers. The President's proposal calls for such an adjustment, but the current state of knowledge in this area is limited and must be strengthened if premiums are to be adjusted appropriately.

I would like to return to the geographic allocation of payments. Mr. Chairman, as you already know, there is substantial variation in spending patterns across states; this variation is magnified at the sub-state level. The problem is that relatively little work has been done to calculate and understand the reasons for geographic variation in health spending. The Federal government last published state estimates on health care spending in 1982. The Health Care Financing Administration is in the process of calculating state level spending estimates for personal health care services for the year 1991. ProPAC currently is conducting an analysis of state variation, as well as urban and rural variation, in health care spending and costs for the aged Medicare population. This information will be useful in understanding the variations in health care spending across areas.

There are tremendous differences across this country, Mr. Chairman, in terms of both the people that use health care services and the health care system that provides services to those people. In our recent June Report to Congress, we described the range of these differences at the state level, looking at population characteristics such as wealth, age and health status, and characteristics of the health care system, such as the supply of health care services, and policy and regulatory environments. Each of these factors affects the level of health care spending; however, we are still in the process of attempting to understand the relationship between these factors and spending patterns.

Absent an understanding of the reasons for geographic differences in spending patterns, a fundamental policy question, Mr. Chairman, is whether to allocate the

premium targets based on historical spending patterns--thereby locking in current spending differentials across areas--or to impose adjusted national spending averages on all areas. Either allocation option would have a significant impact on the distribution of spending and will create winners and losers among states. Most importantly, however, allocation policies will determine the resources that are available to furnish medical services in each geographic area. We must carefully monitor the effects of geographic allocations on subscribers as well the risk adjustments to the health plan premiums. Appropriate allocation decisions and adjustments are even more important in light of the very tight limits on spending increases that the President has proposed.

MEDICARE

Mr. Chairman, I would like to conclude with a brief discussion of the President's cost-saving proposals under the Medicare program, which is responsible for more than one-third of all health care spending. These measures are estimated to reduce the growth in Medicare spending for current services by $124 billion over a five year period. Some of the savings from these initiatives would go towards funding a new prescription drug benefit for Medicare beneficiaries.

As you and the members of this Subcommittee well know, Mr. Chairman, the Omnibus Budget Reconciliation Act (OBRA) of 1993 contained a number of measures designed to achieve significant cost-savings in the Medicare program over the next

five years. The President's proposal would result in further reductions in the growth of the Medicare program.

The Medicare prospective payment system (PPS) has been very effective in controlling Federal health care spending. Since the implementation of PPS, the rate of spending has slowed substantially; by the end of the 1980s, the rate of Medicare spending growth was below that of national spending.

The decline in spending growth for hospital inpatient services is a major reason for the overall Medicare spending slow down. While the growth in Medicare hospital payments slowed, hospital costs continued to rise. By 1991, Medicare payments represented about 88 percent of the costs of treating Medicare patients. This occurred because rather than reducing costs as Medicare payments were limited, hospitals obtained additional revenue from other sources to make up the shortfall. In 1991, Medicare payments were $10 billion below hospitals' reported costs. In addition, hospital sustained losses of $5 billion from Medicaid, and $11 billion from uncompensated care. By contrast, hospital revenue from private payers exceeded costs by $26 billion. This phenomenon of charging privately insured patients more than the cost of their care to cover losses from other sources is commonly referred to as "cost shifting."

To date, Medicare's reductions in the rate of hospital spending growth have had little effect on hospital performance because hospitals were able to cost shift. Under the President's plan, hospitals will not be able to generate extra revenue from the

private sector because of the tight premium controls. If the limits are effective, the implications for patient care are unknown. We are moving, Mr. Chairman, into an area in which we have little experience. It is clear, however, that we cannot rely on the lack of adverse effects from past Medicare cuts to be indicative of what will happen in the future.

The President's proposals would continue to constrain the annual PPS updates to a level well below the current increases in costs per case. It also would reduce payments for capital, outpatient hospital services, and other facility services. In addition, the President proposes reductions in the special adjustments for teaching and disproportionate share hospitals. These spending reductions, together with large decreases in Medicaid disproportionate share payments, will have important consequences for these special hospitals.

The President believes these special adjustments will no longer be necessary because his proposal would provide health care coverage for the uninsured; it also would create a new fund for academic medical centers. Nevertheless, these payment reductions, together with new revenues from previously uninsured patients, will result in a redistribution of available funds among hospitals. Consequently, it is necessary to ensure that the proposals are implemented in a coordinated fashion to prevent the severe financial distress that would affect the most vulnerable hospitals.

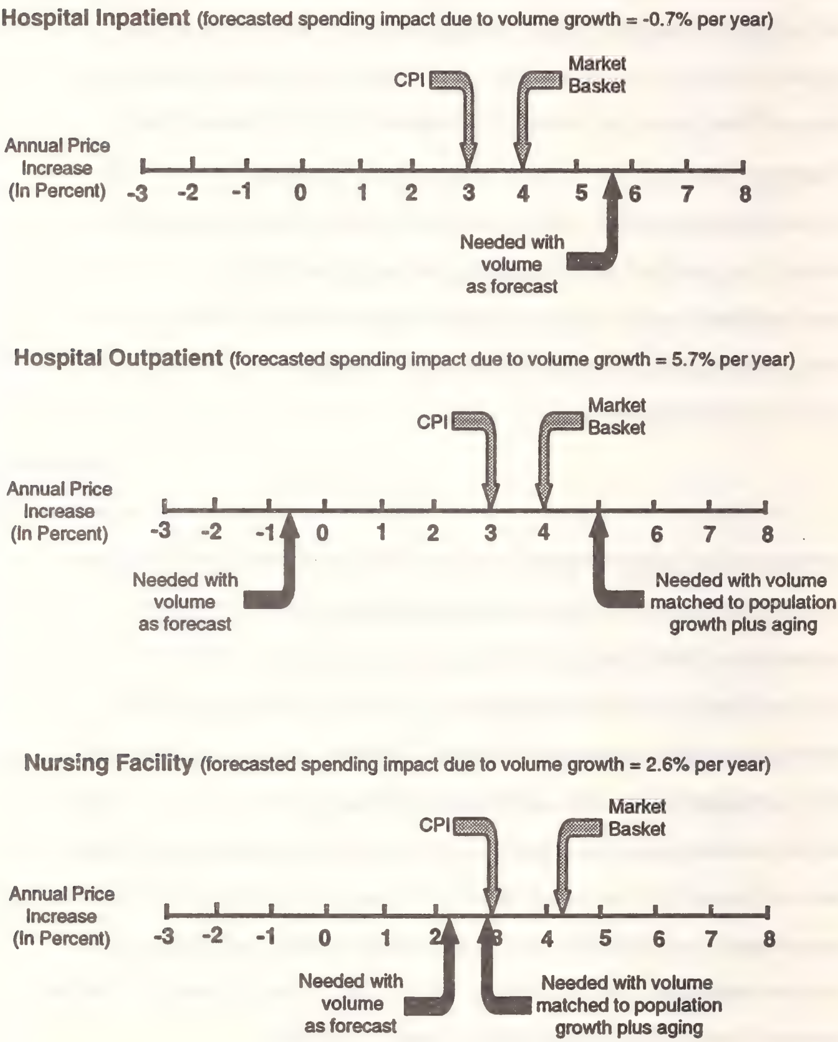
CONCLUSION

The President's proposal to cover the uninsured, limit spending increases in the private sector, and slow Medicare and Medicaid spending growth will interact in ways that are difficult to predict. The plan would greatly slow the rate of increase in provider payments and curtail the ability of providers to raise revenues from some payers to cover losses from others. It is anticipated that the increased financial pressure will lead providers to furnish services more efficiently. The proposal's premium limits and Medicare reductions, however, would lead to an unprecedented slowing in the growth of provider revenue. We need to carefully monitor the effects of these reductions to ensure they are applied in a way that will not adversely affect access and the quality of services furnished to Medicare and Medicaid beneficiaries, as well as all Americans.

Mr. Chairman, any approach to health care reform that successfully controls the growth in health care spending and provides health care coverage for the uninsured population will have a substantial impact on hospitals and other providers of health care services. Under the President's proposal, we should expect substantial changes in the way health care services are delivered. The proposal could lead to large redistributions in payments across geographic areas and among types of providers. Many of the effects of the proposal will be determined by important technical details and the responses of plans and providers. The allocation of premiums to the health plans and the ability of the plans to furnish necessary and appropriate services for the premium amount are critical elements of the proposal. ProPAC will be pleased to continue working with this Subcommittee and the Congress as you seek to implement solutions to the problems facing America's health care system.

I would be pleased to answer any questions you or other members of the Subcommittee may have.

Chart 1. Price Increases Needed to Meet a Spending Growth Target Based on GDP Under Alternative Volume Assumptions, 1995-2000



SOURCE: Market baskets forecasted by the Health Care Financing Administration, effective September 1993. All other variables forecasted by the Congressional Budget Office, effective October 1993.

Mr. WAXMAN. Thank you both very much for your testimony. Dr. Thorpe testified that the President considered and then decided not to rely on incorrect health costs.

Instead, he is proposing to combine managed competition with a back-up system of enforceable premium caps.

Dr. Altman, you seem to think that was an appropriate decision if we really want to get costs under control, the market alone won't do the job for us.

Could you elaborate on that point please?

Mr. ALTMAN. My own personal comments: Managed care has been effective in many parts of the country. When you look at the numbers, 10 percent, maybe 15 percent reductions in spending for those populations, some of which is the result of maybe taking in less sick people.

But let's say 10 percent, if you are talking about reductions in 30, 50 or 100 percent, if you are talking about a rate of the growth that has been growing at three times inflation and bringing it down to no real growth, even the strongest advocates for the market do not believe managed care alone can bring us that far down.

They would suggest we should not go down that far; but if you need to go down for savings or economy, I don't believe the market alone will do that.

Mr. WAXMAN. How can we contemplate bringing 37 million more people into the system?

Mr. ALTMAN. The President's combined managed care and managed competition with a premium control system which I believe will go into effect.

In my mind, I don't think there is any doubt that to bring the level of spending down to no real growth or slight real growth will require the use of that back-up system, and that includes the savings for the uninsured.

Mr. WAXMAN. Can we ensure a universal coverage with an employer-based system is not affordable with a back up of premium caps or restraints other than the market forces themselves?

Mr. GINSBURG. Both from the perspective of the public payers and employers we no longer have the luxury to try something and let the costs go up.

I think we are at the point now where no one is willing to go much further without strong steps to control costs. So our ability to experiment with a new idea is less than it was in the past.

Mr. WAXMAN. One of the proposals in the Congress says we won't have a mandate on employers to cover their employers and which will not have cost constraints other than market forces.

What do you think would happen if we did something like that Dr. Altman? Would we get universal coverage or have some people paying more for the insurance they now have?

Mr. ALTMAN. I may have missed the import of your question, Mr. Chairman. But I think these are separate issues. They have been chosen on the basis of the way we choose to finance universal coverage.

The President has chosen, and several of the alternatives that are being presented have chosen, to finance universal coverage by the use of the savings.

We could have chosen to finance it through some broad based, some would say, tax increase. I would call it a savings rebate.

I think Dr. Thorpe testified before you correctly, indicating that over time the vast majority of Americans who are now well insured will save significant amounts of moneys under health care reform.

In my own opinion—again, not the Commission—is that we who are well insured should be prepared to give back some of those savings to cover everything.

So that is one option. If you choose the way the President has done it or the way Senator Chafee and many others do it through savings, then you have to begin to take a stronger hammer, as you used the word, or a stronger fist, to control spending.

Mr. WAXMAN. We hear people saying tax increases are off the table except for the cigarette tax. So the premise of most of the proposals pending before Congress at the present time is to get savings in the system in order to expand that system to people who are now not covered.

We hear people say let's do it through market forces alone. I hear both of you saying you don't think that will work to accomplish the objective of getting universal coverage.

Mr. GINSBURG. I would say that, given the environment of not being able to raise taxes except, perhaps, for cigarettes to pay for bringing more people into the insurance system, it means that we have to be a lot more confident that we are going to achieve savings than we would be if we were using taxes.

I think that brings up a situation where we need to bring some regulation, whether it is premium limits or rate setting, in order to guarantee that at least some of the savings are accomplished.

Mr. ALTMAN. Mr. Chairman, let me make two points. First, if you are willing to wait a long time before bringing them on and you bring a little savings every year, I think you could eventually bring everybody on.

I am not prepared to tell you how many years that is going to be, but it won't be 2 or 3.

I have a problem—and maybe it is me—but we have two insurance systems out there, the Medicare insurance system and the private insurance system. The President is right, and his advisors, that we are going to see significance savings. But we are only choosing to use the savings from the Medicare program to pay for this.

If we looked, at that time, broader and said we will use all the savings so we don't have a tax increase, rather we are talking about allocating some savings to get the system going then, over time, you are going to see them.

Maybe it is just the way I look at it. I think you can use savings to fund this, but I think you have to use the savings from all of us, not Medicare alone, unless you are prepared to see a significant reduction in the Medicare side alone.

All I can say, from our experience, is we have no experience on what that will do.

Mr. WAXMAN. You are not suggesting that there is not a cost containment feature on the private side and only the public side of health care services?

Mr. ALTMAN. No. But there is no allocation of those savings back to pay for the uninsured except for the 1 percent tax on the large employers and indirectly through the savings——

Mr. GINSBURG. I think there are some revenue estimates that if employer contributions don't increase as much as that, there will be less revenue lost from that.

Mr. ALTMAN. There is some of that, but it is not equal to the contributions being made by Medicare and Medicaid.

Mr. WAXMAN. My time has expired.

Mr. Bliley.

Mr. BLILEY. Mr. Ginsburg, the implications on the charts of what would happen if there is movement from the less expensive plans to the most expensive one was that it was unrealistic, that all the movement would be in the other direction from high cost to low cost plans.

What budget implications are now under Mr. Thorpe's approach?

Mr. GINSBURG. I thought of that as you were discussing this with him. Something he did not mention was that many of the steps to restructure the market, the recreation of the health alliances and the like, I think will make it easier for consumers to find low-cost plans to close.

I think the shift will be toward the low-price plans and not the high-priced plans, but I cannot guarantee that. And it may not be that way in every area.

A thought I would like to raise is that we could either accept this situation as it is so that switches among plans, in a sense, make it easier or more difficult for plans to meet their premium limits. Or if you wanted to, you could restructure the way premium limits work so that a movement from one plan to another doesn't count and you just tabulate the premiums as if there was no movement.

So if you think the problem is really serious, you might want to go in that direction.

Mr. BLILEY. Thank you. I would like to ask this question of both of you.

This chart examines the structural ways that payments are capped. Capped payments will place incredible strains on both the alliance and the health care plans since both coverage and benefits are federally guaranteed.

Let's examine the caps. First there is a CPI on Federal and State payments for cash eligible Medicaid recipients.

According to the administration's figures, this cap puts Federal Medicaid payments for cash eligible by $22.3 billion.

Second, the bill has premium caps on private health care premiums at the CPI when fully phased in.

Third, there is a cap on Medicare recipients who have been integrated into States' single-player systems or regional alliances.

Finally, the small businesses and low-income families is capped at section 9102(e). The alliance and the health plans are placed in a technical position. While all sources of revenue are capped, it must provide open ended entitlement to all individuals who subscribe.

Isn't this system a guarantee for insolvency?

Let's start with you, Dr. Altman.

Mr. ALTMAN. Clearly, the system is designed to put a lot of financial pressure first on the plans and then on the regions to bring their total spending in line.

I don't know if it was Mr. Wyden or one of you who talked about technology. There is a lot of excess capacity out there. The question is going to be: How are we going to get that excess capacity out of the system?

I think they are going to rely primarily on the plans; but, ultimately, it may turn out that the regions may have to help those plans in bringing the technology on line.

It is conceivable down the road that if nothing works, you could have a problem in insolvency. But I think the hope is, by putting these budget controls first on the plans and then the regions, you can make the system a lot more efficient than it is today. That is the plan.

But if it doesn't work, then we are heading for financial problems. Insolvency is one, and raising the caps is another.

Mr. BLILEY. Do you agree with that Dr. Ginsburg?

Mr. GINSBURG. Yes, I generally do. I don't see the alliances being the organizations risking insolvency. I think what we are concerned about is whether, if we give the plan a very hard constraint on what the premium can be, whether, in fact, the plans will go insolvent or, I think more likely, whether plans will leave certain markets and we could find ourselves in situations where there doesn't seem to be enough insurance offered to serve the population in that market.

In theory we can set a cap as low as we want. If we are willing to enforce it, we will get the savings, but realistically we have to be concerned with how much money plans can save and whether we are asking them to do more than they are capable.

Mr. BLILEY. Thank you very much.

Mr. WAXMAN. Thank you.

Mr. Wyden.

Mr. WYDEN. Dr. Altman, in your view, how do premium controls weed out the wasteful volume-driven spending rather than spending that, we would agree, is in the patients's interest.

Mr. ALTMAN. The expectation is that the plans faced with this restrictive budget will bargain much tighter with the hospitals and the clinics and force them, given the fact that they have excess capacity, to accept lower payments in return for volume which will then force the hospitals and others and equipment to look hard and fast at their excess capacity and begin to pull it off line because they cannot afford to support it by charging higher prices, which is what they are now doing.

So it is market driven. How do we get the real estate market to eventually get the excess capacity of office space out there? That is the model.

Mr. WYDEN. We have a lot of unused office space out there.

Mr. ALTMAN. I gave a talk last week at the Land Institute. There were a lot of people there. They were talking about that the vacancy rate is going down. But it is a slow process. It doesn't happen overnight. That is the market-driven mechanism for weeding out.

Now, there is an alternative which is what other countries use, and what we have toyed around with, which is a supply constraint

from government. Theoretically, it makes sense, but we have not been able to hold the system tight. Neither have worked. And we have a lot of excess capacity.

Mr. WYDEN. This leads into the question I have about technology. To me, the proposal completely misses the boat here. Technology is responsible for about 40 percent of the rate of growth in spending.

We saw all over the 1980's the proliferation of the "me too", drugs, and devices superior to anything out there. Those technology policies seem to drive a lot of what we are also seeing in terms of volume-driven inefficiency.

I keep hearing about how we are going to have the great outcomes assessment process. We have this itty-bitty agency, the Health Care Office of Research, which I don't think is in the ballpark of doing what needs to be done for technology assessments.

The administration is incentivizing the private sector to give comparison data at the time someone files an application at the Food and Drug administration.

I am curious, if we don't do it that way, where are we possibly going to get that massive amount of money that is going to be needed to do the useful technology assessment outcomes analysis kinds of approach that I think both of us would agree go hand in hand with this volume-driven mess we have on our hands?

Mr. GINSBURG. Mr. Wyden, when we are trying to force, whether it is through competition or caps, a more efficient health care system, the ultimate work is going to have to be done by physicians who decide which of the services they provide or they order the important ones, and which ones there patients can do without.

We have to focus on giving physicians the tools to do this job right. I know many, including myself, have been disappointed with the slow pace by which Technology Assessment and Outcomes Research has moved forward.

We can only, to the extent that we can, communicate this to decisionmakers, that if we want a very radical change in the growth of costs in the system, that if the job is going to be done, well this is the time when we really need to pursue these policies to develop the tools so their physicians can economize.

Mr. WYDEN. I envisage, in my proposal, that we have an electronic bulletin board made available to HMO's, clinics across the country, so physicians can use it when they make these decisions.

One last question, Dr. Altman. I have heard you touch on this before, and it strikes me as important. What are your feelings about the way employers are really being taken out of the equation in a very significant way in terms of cost containment?

Are you concerned about that? And if so, what might we do on Mr. Waxman's subcommittee to address this?

Mr. ALTMAN. I believe cost containment is very tough. I believe we should have all the allies and all the equipment and all the people trying to do it out there.

Now, the employer community has had a mixed success rate, but then so have we in the government. But they have done a number of things. If we would not have managed care out there the way we have it for the nonemployed community, we would not have the emphasis on preventive care and a lot of others.

Employers have been pushing hard to constrain costs. I think they have been fairly responsible. Sure some have cut benefits and moved costs on. We have all kinds of examples where they have not behaved like they maybe should have.

I am very concerned in the President's current bill that not only have we pushed every employer out under 5,000 but the incentives in the existing system make it prohibitively expensive, even for firms over 5,000, to stay and run their own alliance.

I know why they did it. We can spend time on that. But there is a fear on my part that by pushing all the employers out you put all the responsibility on the regional alliances and on the plans.

My hope would have been that we keep more of the employers in the equation. I would lower the rate from 5,000 to 500 or 1,000. I would strengthen the employers' responsibilities. I would keep them under the budget and keep them under restrictions so they don't do things inconsistent with the rules.

But from my way of thinking, we need all the help we can get controlling costs. And I would not move them out of the system quite as summarily as this plan has done.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. McMillan.

Mr. MCMILLAN. Dr. Altman, you described this plan as shifting savings from Medicare to cover the costs of others. I don't see that at all. There are presumed cost reductions in the Federal Government on Medicare, but they are all spent on senior citizens.

More is spent on the addition of long-term care and pharmaceuticals than is saved by whatever the 24 procedures they are going to outline is in savings to do that.

I don't see hospitals being relieved at all. Medicare will operate under the same premise it is operating under now except the hospitals will not be able to cost shift. That will be an intolerable situation.

I think the answer is to try to do some things that reinforce getting control of costs, the things that are driving up all costs, not just Medicaid but a few others. There are some really strong malpractice reform procedures that have been introduced here.

They are not in the President's bill. I think they should be. His administrative cost reforms are probably on target and should be part of most any legislation.

I think the antitrust provisions are weak which limits the ability of providers to form constructive joint ventures that are cost-effective. That needs to be strengthened.

Dr. Ginsburg, you mentioned practice guidelines. I have not seen them in this legislation. I think they are absolutely essential to outcome evaluations, to cost-effective management, to malpractice reform.

Doctors, in effect—just like you suggest, in effect, are elevating cost-effective management of the system with other values.

How do we get attention brought to bear upon practice guidelines? It has actually been declining in terms of volume so that if you ask them, the hospitals in this country, they pay the additional amount.

They are going to have to look either to other revenues or substantially cut costs. All I was trying to say is we have no experi-

ence really in understanding the implications of that for the care that is provided in those institutions.

Mr. MCMILLAN. I believe there is enormous opportunities for the hospitals to reduce costs. Incentives are not in place to cause them to reduce costs. You are going to cost shift before you reduce costs, if you can.

Mr. ALTMAN. I don't disagree with that. We don't know how you can push that before real cuts that affect services and quality of care.

Mr. WAXMAN. Thank you, Mr. McMillan.

Dr. Altman and Dr. Ginsburg, thank you very much for your testimony today. We look forward to getting your guidance on that issue as we continue.

Mr. ALTMAN. Thank you very much.

Mr. WAXMAN. Our next witness represents private purchasers of health care, Richard Cordtz, Secretary Treasurer of Service Employees International Union.

Your prepared written statement will be included in the record in full. Without objection, I would like to ask you to limit your oral remarks to 5 minutes so that we will have time for questions.

STATEMENT OF RICHARD W. CORDTZ, SECRETARY-TREASURER, SERVICE EMPLOYEES INTERNATIONAL UNION

Mr. CORDTZ. My name is Richard Cordtz, and I am Secretary-Treasurer of the Service Employees International Union with over 1 million service-sector workers in the United States, Canada, and Puerto Rico, SEIU is the fourth largest union in the AFL-CIO, and the largest union representing service workers.

On their behalf, I would like to thank Chairman Waxman for this opportunity to testify on one of the most critical issues facing our Nation today.

Let me also take this opportunity to applaud the chairman for his outstanding leadership in this area over the years.

After almost 50 years of struggle, we are on the verge of bringing much needed reform to our Nation's health care system, The legislation submitted to the Congress by the President and Mrs. Clinton represents a historic step forward for working people in the United States.

One of the key components of the Clinton plan is a comprehensive strategy to get health care costs under control. By using a blend of regulation and market pressures, the annual increase in health care costs will gradually be reduced to a manageable level.

Opponents of the President's plan have contended that with a little tinkering here and there, market forces alone would be sufficient to accomplish this task. In particular, advocates of a "pure managed competition" approach have argued that by capping the tax deductibility of health insurance benefits, consumers can be made more "conscious" of the cost of those benefits, forcing them to shop around for the lowest cost health care plans. This is meant to lead to enhanced price competition between health plans, leading to lower health care costs.

We feel that the advocates of unbridled managed competition are dangerously mistaken. First of all, no other nation in the world relies solely on the market to control health care costs. While the

specific regulatory tools vary from country to country, all nations with national health care systems have imposed some kind of limit on the amount they spend on health care.

Second, consumers are already very conscious of the cost of health care because of the significant level of cost sharing that has been imposed over the past few years.

While the Clinton plan does contain a number of provisions designed to enhance competition between plans, the administration has wisely chosen to backstop the market by placing limits on the premiums charged by health insurance plans.

The Service Employees International Union is strongly supportive of the President's plan, and I want to spend some time today explaining why. I also want to state clearly why we feel many of the other health care reform bills would be highly ineffective in controlling costs.

Consumers are not the problem.

The first issue I want to address is the argument that health care costs are out of control because consumers are demanding "too much" health care. Advocates of pure managed competition argue that because employers and insurance companies pay most of the cost of health care, workers have no incentive to be cost conscious when they shop for health insurance and health care. As a result, they join plans that are inefficient, and they consume "too much" care.

As someone who has personally negotiated hundreds of contracts, I can tell you that our members are very conscious of the cost of health care. Health care is the number one issue at the bargaining table.

Workers are paying a greater share of the premium than they used to, they are paying more out of pocket for health care services, and they have given up wage increases in order to preserve their health benefits.

Despite the fact that consumers are paying more for their health care every year, there are some legislators who seem to feel that the solution to consumers paying too much is to charge them more. Whether the benefit tax is levied on workers, as in the Chafee proposal, or employers, as in the Cooper/Grandy Bill, H.R. 3222, it is workers who will eventually end up paying the cost.

Experience provides little support for the assumption that shifting more of the burden of health care costs to workers will keep costs under control. Heightened consumer sensitivity to prices failed to slow health care costs in the 1980's. The explanation is that consumers don't make the "big ticket" medical decisions, doctors do and hospitals do.

Furthermore, those consumers who need expensive medical procedures and tests tend to be extremely sick and in no position to shop around.

In any given year, the sickest 5 percent of the population accounts for about 60 percent of total health expenditures. For this reason, HMO's and other managed care networks have found that hospital utilization and high tech controlling procedures is the most effective way to manage health care costs. The failure of the voluntary cost control efforts have not succeeded.

Over the last decade, health care has been at the top of the collective bargaining agenda. While disputes over health care costs often made bargaining more contentious than it might otherwise have been, labor and management were also able to work together to pioneer new cost-containment strategies, such as utilization review and managed care.

Two, we have found these innovations cannot keep costs under control over the long-term.

About 6 years ago, members of my own local, Local 79 which represents low-wage building service and health care workers in Detroit opted to switch from their indemnity plan to a HMO to save money.

However, within a few years, the cost of the HMO was actually higher than the old plan, and the workers began to lose benefits.

In my written testimony, I have provided numerous examples of how employers, by employers' efforts to contain costs, ultimately failed.

A third set of issues that I want to address are the health alliances and their potential for cost containment.

As you know, Mr. Chairman, in your State of California there is a plan that is considered to be a model for health alliances and managed competition. That is called CalPERS.

We represent more than half of the active workers enrolled in CalPERS. This past year, CalPERS held premium increases for the plans to an average of 11.5 percent compared to 10 percent nationally.

I think that there are at least three lessons that can be drawn from the CalPERS experience that would argue in favor of President Clinton's's approach.

The first is that the discipline of an overall budget is critical to keeping costs under control. Before the imposition of budget premiums in a CalPERS system were increasing faster than the national average.

The second lesson is that the consumer must be able to control the health alliance. The CalPERS board represents public sector workers and employers, not providers or insurers. Their presence ensure that CalPERS' negotiators are going to aggressively bargain with plans to keep costs under control.

The third lesson is that, while CalPERS may have saved money for the employers, insurers and providers may have simply shifted their costs to other California employers.

For example, Foundation Health Plan held the CalPERS premium increases to zero for 1993 and 1994 but gave other customers increases of 5 to 7 percent.

Mr. WAXMAN. Mr. Cordtz, your statement will be in the record. I would like to pursue a few questions with you, if I might. I think some of the points that you are making will probably come out here as well.

[The prepared statement of Mr. Cordtz follows:]

STATEMENT OF

RICHARD W. CORDTZ, INTERNATIONAL SECRETARY-TREASURER

SERVICE EMPLOYEES INTERNATIONAL UNION

My name is Richard Cordtz and I am the Secretary-Treasurer of the Service Employees International Union. With over one million service-sector workers in the United States, Canada and Puerto Rico, SEIU is the fourth largest union in the AFL-CIO, and the largest union representing service workers.

SEIU members come from both the public and private sectors and include 450,000 health care workers who work in acute care hospitals, nursing homes, mental hospitals and other health care facilities. On their behalf, I would like to thank Chairman Waxman, and the other members of the committee for this opportunity to testify on one of the most critical issues facing our nation today. Let me also take this opportunity to applaud the chairman for your outstanding leadership in this area over the years.

After almost 50 years of struggle, we are on the verge of bringing much needed reform to our nation's health care system. The legislation submitted to the Congress by the President and Mrs. Clinton represents a historic step forward for working people in the United States.

One of the key components of the Clinton plan is a comprehensive strategy to get health care costs under control. By using a blend of regulation and market pressures, the annual increase in health care costs will gradually be reduced to a manageable level.

Opponents of the President's plan have contended that with a little tinkering here and there, market forces alone would be sufficient to accomplish this task. In particular, advocates of a "pure managed competition" approach have argued that by capping the tax deductibility of health insurance benefits, consumers can be made more "conscious" of the cost of those benefits, forcing them to shop around for the lowest cost health care plans. This is meant to lead to enhanced price competition between health plans, leading to lower health care costs.

We feel that the advocates of unbridled managed competition are dangerously mistaken. First of all, no other nation in the world relies solely on the market to control health care costs. While the specific regulatory tools vary from country to country, all nations with national health care systems have imposed some kind of limit on the amount they spend on health care. Second, consumers are already very conscious of the cost of health care because of the significant level of cost-sharing that has been imposed over the past few years.

While the Clinton plan does contain a number of provisions designed to enhance competition between plans, the administration has wisely chosen to backstop the market by placing limits on the premiums charged by health insurance plans.

The Service Employees International Union is strongly supportive of the President's plan and I want to spend some time today explaining why. I also want to state clearly why we feel many of the other health care reform bills would be highly ineffective in controlling costs.

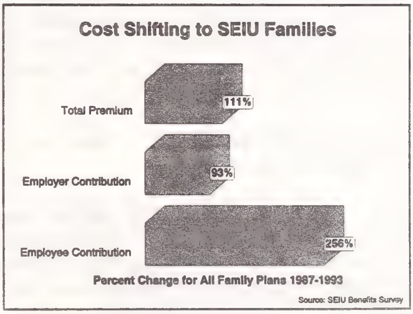
Consumers Are Not the Problem

The first issue I want to address is the argument that health care costs are out of control because consumers are demanding "too much" health care. Advocates of pure managed

competition argue that because employers and insurance companies pay most of the cost of health care, workers have no incentive to be cost conscious when they shop for health insurance and health care. As a result, they join plans that are inefficient, and they consume "too much" care.

As someone who has personally negotiated hundreds of contracts, I can tell you that our members are *very* conscious of the cost of health care. Health care is the number one issue at the bargaining table and the number one cause of strikes. Workers are paying a greater share of the premium than they used to, they are paying more out-of-pocket for health care services, and they have given up wage increases in order to preserve their health benefits. It should also be noted that most workers aren't able to "shop around" for health plans because it is the employer who chooses what plan to offer.

Over the past six years, SEIU family premium contributions have risen an astounding 256 percent, nearly three times as fast as the increase in employer contributions, which rose 93 percent. Workers with family coverage now pay almost $1,000 a year on average in premiums payments alone, up from just $270 just six years ago.



Currently, 80 percent of the SEIU family plans which were surveyed require employee contributions for family coverage, with employees paying an average of 18 percent of the cost, compared to 11 percent in 1987.

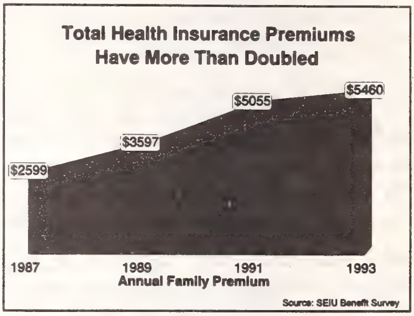
Premium payments are only a part of a worker's total health care bill. Workers also have to meet their deductibles, as well as foot the bill for copayments on physician's visits, prescription drugs, and hospital stays. Family deductibles for SEIU members have increased 16 percent over the past six years. Copayments for major medical expenses have risen from 16 percent of the cost of the service in 1989 to 18 percent in 1993.

Despite dramatic increases in employee cost-sharing, health premiums have continued to climb at double-digit rates. Today, total SEIU family premiums average $5,460 -- more than double the average premium of $2,600 just six years ago. I want to emphasize that the reason that premium levels for SEIU plans are so high is *not* because our members have "cadillac plans." SEIU members are concentrated in some of the highest cost areas of the country, such as the northeast, the industrial midwest, and California, and many work for smaller employers and industries, like health care, that insurers have designated as high-risk.

Despite the fact that consumers are paying more for their health care every year, there

are some legislators who seem to feel that the solution to consumers paying too much is to charge them more. Whether the benefit tax is levied on workers, as in the Chafee proposal, or employers, as in the Cooper/Grandy Bill (H.R. 3222), it is workers who will eventually end up paying the cost.

Experience provides little support for the assumption that shifting more of the burden of health care costs to workers will keep costs under control. Heightened consumer sensitivity to prices failed to slow health care costs in the 1980s. The explanation is that consumers don't make the "big ticket" medical decisions -- doctors do.



Furthermore, those consumers who need expensive medical procedures and tests tend to be extremely sick and in no position to shop around. In any given year, the sickest five percent of the population accounts for about 60 percent of total health expenditures. For this reason, HMOs and other managed care networks have found that controlling hospital utilization and high tech procedures is the most effective way to manage healthcare costs.

Voluntary Cost-Control Efforts Have Not Succeeded

Over the last decade, health care has been at the top of the collective bargaining agenda. While disputes over health care costs often made bargaining more contentious than it might otherwise have been, labor and management were also able to work together to pioneer new cost containment strategies, such as utilization review (UR) and managed care.

If there is one thing that the Clinton plan and some of the competing plans share, it is an assumption that these strategies can play a role in keeping health care costs under control. Our members' experience is that while managed care, UR, and other innovations can produce "one time" savings, especially by cutting administrative costs, they cannot keep costs under control over the long term.

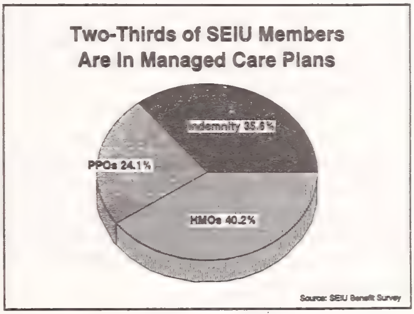
For example, members of SEIU Local 74, which represents service workers in public school districts in New Jersey, have faced a number of changes in their health care plan. In 1986, the plan began to require mandatory second opinions before surgery. Most recently, the plan moved to cap benefits, such as chiropractic and podiatry services, that were previously unlimited. Out-of-pocket costs for workers have increased dramatically over the past five years because payments of providers have been frozen and have not kept pace with the cost of medical procedures. While all of these changes produced one-time savings, none have been able to blunt

the relentless year-to-year increase in costs.

In the early 1980s, SEIU Local 668, which represents social service workers in the state of Pennsylvania, negotiated with employers over a number of cost-control provisions (second surgical opinion, pre-admission certification, generic drugs, etc.) that were instituted for most contracts. These measures were successful for about three to four years. By the time the contracts were up for renegotiation, costs had begun to rise again and employers were asking for further concessions. The next round of negotiations saw the introduction of HMO and PPO options, as well as increased premium sharing. Despite the introduction of all of these measures, costs continue to rise.

SEIU Local 750, which represents building service workers in Orlando, Florida, has also experimented with the use of HMOs and PPOs to keep costs under control. Workers have been offered a choice of 3 HMOs and 1 PPO for over a decade. However, in order to keep costs down, they have been forced to change vendors every two years. These changes often result in a disruption of established relationships with physicians and other providers.

Rising health care costs are also making it more difficult for Local 750's unionized cleaning contractors to compete with non-union contractors who do not provide benefits. Local 750 reports that one of its contractors lost a contract with Delta Airlines that it had held for over eight years to a non-union contractor. The non-union contractor did not provide health insurance for its workers, and thus was able to underbid the unionized contractor.



Many employers have increasingly chosen to control costs by moving their workers into more restrictive plans that limit a worker's choice of provider. As a result, more and more employers offer only an HMO plan. Over the past three years, members of SEIU Local 99, which represents school employees in the City and County of Los Angeles, have faced a gradual erosion of their ability to choose their own providers. In 1992, the county switched from a self-insured indemnity plan to a PPO. A pre-existing condition exclusion was added for new-hires as well as a mandatory mail-order drug program for maintenance drugs. In 1993, additional changes were made. The PPO was changed to an HMO with an out-of-network option. The County also switched to an HMO for its dental coverage, and vision coverage was significantly cut back.

About 6 years ago, members of my old local, Local 79, which represents building service and health care workers in Detroit, opted to switch from their indemnity plan to an HMO to save

money. However, within three years the cost of the HMO equalled that of the previous indemnity plan. In the fourth and fifth years, the cost of the HMO was actually higher than the indemnity would have been and the workers also began to lose benefits. At the end of the fifth year, the workers dropped the HMO and went back to the original indemnity plan.

I don't want to give the committee the impression that our members have uniformly negative attitudes toward HMOs and PPOs. In many cases, we have had to fight hard to get employers to provide them. We realize that no health plan is going to suit every single person and we want to give our members the widest range of choices that we can. What we object to is when the employer tries to make an HMO or a similarly restrictive plan the only option available to workers.

Our experience has been that no matter what kinds of cost control strategies our members have tried or had imposed on them, costs continue to rise. I'm sure that over the next few months the committee is going to hear testimony from employers who claim they've found the "magic bullet" that will keep health care costs under control. If reform is not enacted, I'm sure that in just a few years those employers will be throwing up their hands and crying "nothing works!"

Health Alliances: The Lessons of CalPERS

One employer that has had a remarkable level of success in the past year has been the State of California. The California Public Employees Retirement System (CalPERS), which administers a multi-employer health benefits plan for 887,000 state and local government workers, family members and retirees. This past year, CalPERS held premium increases for its plans to an average of 1.5 percent, compared to 10 percent nationally. For the coming year, CalPERS has announced that it will attempt to negotiate a five percent reduction in premium costs for its members.

The CalPERS experience is important because the system has served as a model of managed competition in action. In both the Health Security Act and the Cooper bill, large health insurance purchasing cooperatives like CalPERS are meant to play an important role in keeping costs under control. These cooperatives (called Health Alliances in the Clinton proposal and Health Plan Purchasing Cooperatives in the Cooper/Grandy Bill) would pool small and medium size employers in order to spread risk and cost more widely, thus making insurance cheaper for cooperative members.

There are also significant differences, however, in the role that health alliances play in the two proposals. President Clinton's Health Security Act would require most businesses and consumers to purchase insurance through regional alliances that negotiate aggressively with plans to keep premiums under control and would provide a backstop limit on the annual increase in plan premiums. Under the Cooper/Grandy bill, by contrast, alliances would only be for small employers with 100 or fewer employees and they would serve more as match-makers than negotiators.

SEIU, which represents roughly half of the active employees enrolled in CalPERS and has worked closely with the Advisory Committee and the CalPERS board, set out to evaluate the lessons that the CalPERS experience offers for national health care reform. The results were published in an SEIU Issue Paper released last March.

For most of the 1980s, CalPERS had most of the elements that proponents of managed competition argue must be present if the system is to work. Over 20 plans, most of them HMOs, competed with each other for enrollees. The vast majority of enrollees are in managed care plans, such as HMOs or PPOs. There were significant differences in the prices charged by plans and the state government contributed a fixed amount per worker (although the amount was not tied to the lowest cost plan), so consumers had an incentive to enroll in lower cost plans.

Despite the apparent existence of a competitive market, CalPERS actually fared worse than other employers nationally in managing health care costs during the 1980s. According to Lewin-ICF (now Lewin-VHI) data, average family premiums for the nation as a whole increased 9.4 percent annually between 1982 and 1992, compared to 12.9 percent for CalPERS fee-for-service plans and 9.8 percent for CalPERS HMO plans.

Only in the last two round of negotiations, for the plan years 1992/93 and 1993/94, were costs held below national trends. CalPERS limited average health plan rate increases to 6.1 percent in 1992/93 and an even lower 1.5 percent in 1993/94. Especially impressive was CalPERS ability this past year to wring out an average price reduction of 0.2 percent for its 19 HMOs, which cover 78 percent of the population.

CalPERS achieved this remarkable level of cost containment by behaving exactly as the "health alliances" are intended to operate under the Clinton plan. In response to California's fiscal crisis, the state government effectively imposed a budget on CalPERS by freezing contributions to it. CalPERS used its clout as a multi-employer purchasing cooperative--a giant consumer--to aggressively negotiate limits on premium increases.

I think there are at least three lessons that can be drawn from the CalPERS experience that would argue in favor of President Clinton's approach. The first is that the discipline of a budget is critical to keeping costs under control. Before the imposition of a budget, premium rates in the CalPERS system were increasing faster than the national average.

The second lesson is that businesses and consumers must be able to control the Health Alliances. The CalPERS board represents public sector workers and employers, not providers or insurers. Their presence ensures that CalPERS negotiators are willing to aggressively negotiate with plans to keep costs under control.

The third lesson is that while CalPERS may have saved money for its employers, insurers and providers may have simply shifted those costs to other California employers. For example, Foundation Health Plan held its CalPERS premium increase to zero for 1993/94, but gave other

customers increases of five to seven percent. Qual-Med, a large HMO, increased its premium for CalPERS a modest 1.5 percent, while increasing premiums for the City of San Francisco by 9.2 percent. Kaiser-Permanente of Northern California cut its CalPERS premium by 2.2 percent, while raising the premium it charges the City of San Francisco by three percent.

The rate of growth in health care costs for the state as a whole has been unaffected by CalPERS, suggesting that even large purchasing cooperatives cannot effectively control costs unless most employers are members of the same pool.

If the so-called "opt-out" threshold for participation in Health Alliances is lowered, or if they are made voluntary, it will be much easier for health plans to continue to play the cost-shifting game. Insurers will continue to segment the market, offering discount rates to large employer groups and passing on the costs to smaller groups with less market power.

Universal Coverage and Cost Control

While the focus of this hearing is on cost control, I think that it is impossible to discuss cost control without discussing the role that universal coverage can play in lowering health care costs. Right now, every bill we pay and every premium payment we make contains a hidden surcharge that goes to cover the more than $25 billion a year in care that hospitals provide to the uninsured.

Many employers who are currently providing insurance are paying more than their fair share because they are providing coverage the working spouses of their employees. In essence, they are subsidizing their competition. That's why the U.S. Chamber of Commerce is supporting the idea of an employer mandate.

The members of the Service Employees International Union have long supported a universal right of access to health care. President Clinton's plan would eliminate existing barriers to coverage and guarantee every American a comprehensive range of health care benefits. No one would be denied coverage because of their income, health or employment status.

Universal coverage has become President and Mrs. Clinton's "line in the sand." The Cooper/Grandy bill, for example, does not guarantee health insurance coverage for every American. Nor do the proposals submitted by Representative Michel or Senators Chafee and Graham. Making health insurance more affordable through voluntary health alliances and tax vouchers simply will not reach many of the uninsured.

Cost Control and the Healthcare Workforce

While I am on the subject of cost-containment, I want to talk about the special concerns of health care workers, which must be addressed as part of national reform. Health care

workers are on the front lines of patient care and have long been advocates of health care reform and strong cost containment measures. They are the ones drowning in the paperwork of the insurance companies. They are the ones who see the people who come to the emergency room because they can't get basic health care any other way. They know better than any of us that it is time to stop talking about health care reform and to start doing it.

But they also know that if the cost control decisions are left solely to hospital administrators and insurance company bureaucrats, they may be the worse for it. That is why any cost containment strategy adopted by the Congress must ensure fairness for health care workers and seek to minimize worker displacement. Funds should be provided to retrain insurance and health workers to match skills to health care sectors that have expanded service needs, using appropriate providers, settings and delivery arrangements.

Cost Control and the Economy

The members of this committee know that health care costs are the sword hanging over the head of our national prosperity. If health care costs continue to rise at the present rate, they will consume one-fifth of our Gross Domestic Product by the year 2000. As more of our national income is devoted to health care costs, there will be less for needed public and private investments in human and physical capital.

Workers will continue to see their wages stagnate or even decline. A recent study by the Service Employees International Union found that if health care costs had only grown as fast as the economy, hourly wages would have been about 46 cents higher on average, an annual loss to workers of almost $1,000. With the economy likely to grow more slowly during the 1990s, the impact on workers could be even more severe. The fact that American workers have had to sacrifice wages in order to preserve their health benefits would make any taxation of their health benefits a bitter pill to swallow.

The recent experience of SEIU Local 31M graphically illustrates the wage-benefit tradeoff that millions of American workers are facing. Local 31M, which represents workers employed by the Michigan Employment Services Commission, recently negotiated an agreement with the state of Michigan which explicitly ties future rates of pay with the cost of group insurance plans. In order to save costs, workers have agreed to the implementation of a managed care program and a "flexible benefits" plan. If cost savings are not realized, these workers will not get their negotiated wage increases.

The growth in health care costs will also impose substantial pressure on government budgets. By the end of the decade, Medicare and Medicaid alone will consume a fifth of all federal revenue. State governments will be similarly burdened, with Medicaid alone consuming 12 percent of state revenues (less grants in aid) by the year 2000. If these projections hold, it will become progressively more difficult for states to finance needed investments in infrastructure, education, or transportation.

The United States is engulfed in a health care crisis that threatens to leave an increasing number of our citizens without access to health care and to rob the treasury of the funds needed for other public investment. Given this situation, the members of SEIU cannot support untested theories and untried approaches.

Conclusion

By way of conclusion, let me say that President Clinton's initiative, and his political commitment to health care reform, offers the best hope for achieving our long sought goal of universal health insurance coverage.

The members of the Service Employees International Union intend to defend President Clinton's proposal against those who will advocate that we move more slowly, make incremental changes, or simply endure our current situation. We are committed to working in coalition with consumers, senior citizens, businesses (large and small), community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank Chairman Waxman and the other members of the committee for this opportunity to testify. We look forward to working with you to make President Clinton's vision of "health care that's always there" a reality for America's working families.

Mr. WAXMAN. You testified that your members and their employers have made strenuous efforts to restrain the rate of increase in health care costs, including, higher out-of-pocket costs.

Evidently, these efforts have not worked to restrain annual cost increases. You indicated your members continue to be faced with trading off wage increases to maintain their health benefits.

What do you think would happen if your members' employers were to join with other employers in voluntary purchasing groups as the proponents of pure managed competition have advocated?

Would that likely hold down health care costs increases and protect workers from further increasing benefits? Or do you think caps are necessary to assure that universal coverage is affordable?

Mr. CORDTZ. Like most of the other cost control strategies that unions tried during the 1980's, purchasing cooperatives would probably show some success for the first couple of years. After that, it is likely that the costs would resume their rapid upward climb.

Mr. WAXMAN. You really think we do need a back up for premium cost increases to be limited?

Mr. CORDTZ. Well, if the Managed Competition Act of 1993 were enacted, you know, such a policy would almost certainly raise costs for our members because employers would seek to dramatically reduce the amount they contributed to their workers' premium payments.

Second, even if workers responded by shifting the lower costs, everything we have seen suggests that people in those plans would still be facing double digit premiums and increases for the next several years.

Mr. WAXMAN. What about the managed competition proposal that Mr. Cooper and others would have us adopt, which would be to limit the tax deductibility paid by employers to the level of the employee's cost plan offered in the area?

The theory seems to be that a change of this kind in the tax code would be a powerful incentive for reducing the rate of increase in health care costs.

You sit at a lot of bargaining tables around the country. What do you think the employees' response to that is likely to be? Do you think you will see an increase in the rate of health care costs? Or will the benefits likely be maintained?

Mr. CORDTZ. I mentioned my old Local 79 at Detroit's Renaissance Center. They opted to switch from an indemnity plan to a cheaper HMO to save money.

Within 3 years, the cost of the HMO equaled that of the previous plan. For the 4 and 5 years, the cost of the HMO was actually higher than the old plan would have been.

At the end of the 5 years, the workers dropped the HMO and went back to the original indemnity plan.

Mr. WAXMAN. If you have the elimination of the tax deductibility or limit of tax deductibility.

UNIDENTIFIED VOICE. We believe that imposing a tax cap would have an impact on the amount of benefits that employers are willing to provide. We also believe firmly that it would not necessarily lower costs.

It would reduce the level of benefits that workers get or force them to be with a carrier, that is, the low-cost plan in the area.

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But that has the effect, as I said, of not necessarily lowering overall costs per dollar benefit but of reducing benefits that workers get.

So we don't think it is a very effective tool, number one.

Two, we also believe that it is a tool that is, again, one of these academic kinds of exercises. There has been a great deal of cost sensitivity introduced into the system.

That alone has not had an impact on controlling costs.

Mr. WAXMAN. I appreciate very much your testimony and your response to these questions. I think it is important that the members have, on the record you, as a consumer representative, what you see as the impact of these various proposals.

Thank you very much for being with us.

Mr. CORDTZ. Thank you, Mr. Chairman.

Mr. WAXMAN. We are going to recess and come back at 1 o'clock.

[Brief recess.]

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Our next panel consists of representatives of health insurers and managed care plans.

John D. Moynahan is Executive Vice President of the Metropolitan Life Insurance Company. He is appearing today on behalf of the Alliance for Managed Competition.

Richard M. Niemiec is Senior Vice President for Corporate Affairs, Blue Cross/Blue Shield of Minnesota.

Samuel Havens is Senior Vice President of the Prudential Insurance Company and is appearing today on behalf of the Group Health Association of America where he is currently Chairman of the Board.

Kylanne Green is Director for Managed Care of the Health Insurance Association of America.

I want to thank you for being here. Your prepared statements, without objection, will be made part of the record in full. We would like each of you to limit your oral presentation to no more than 5 minutes.

Mr. Moynahan we will start with you.

STATEMENTS OF JOHN D. MOYNAHAN, JR., EXECUTIVE VICE PRESIDENT, METROPOLITAN LIFE INSURANCE CO., ON BEHALF OF THE ALLIANCE FOR MANAGED COMPETITION; RICHARD M. NIEMIEC, SENIOR VICE PRESIDENT, BLUE CROSS BLUE SHIELD OF MINNESOTA; SAMUEL HAVENS, CHAIRMAN, GROUP HEALTH ASSOCIATION OF AMERICA; AND KYLANNE GREEN, DIRECTOR, MANAGED CARE, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. MOYNAHAN. Thank you, Mr. Chairman. Good afternoon. I appreciate this opportunity.

My name is John D. Moynahan, Jr. I am Executive Vice President for Metropolitan Life and here today on behalf of the Alliance for Managed Competition, an ad hoc coalition of five companies who, together, provide health coverage to over 60 million Americans.

Aetna, CIGNA, The Prudential, The Travelers, and MetLife got together in the alliance with the goal of working effectively toward comprehensive health care reform.

The alliance supports the Federal enactment of a health care reform bill based on the principles of managed competition. Such a bill would provide the needed structure for the effective operation of a competitive market of private accountable health plans, which integrates the delivery and the financing of health care.

Managed competition through its structure and requirements for markets place accountability allows competing private programs to serve the American consumers with the creativity, innovation, and responsiveness needed to meet their expectations for full access to high quality care on an affordable basis.

In the end, it is these partnerships, and not government regulation, which will be the true engine of lasting government health care reform. The accountable health partnerships in the reform system will be built upon the foundation of a virtual revolution which is already underway in the private marketplace where even now the system is reforming itself through voluntary movement of private health insurance to managed care programs. Such programs are both cost-effective and provide quality service.

According to a Foster-Higgins report released in 1993, HMO's costs 23 percent less than traditional health insurance plans and while their costs do rise, they do so much more slowly than the traditional indemnity plans.

On the service point, large employers surveyed in 1992 said, virtually all of them, 91 percent, that employee satisfaction with health benefits is the same or better under managed care programs.

The President and the First Lady have embarked on a truly historic venture to reform what is, in reality, one-seventh of the American economy. We applaud them for their initiative and their commitment in seeking the needed reforms for our health care system.

And we endorse wholeheartedly the principles that the President embraced in his address before Congress and the Nation on September 22.

As Congress debates the enactment of health care reform in this session, we believe that these principles will and should guide that debate. The ways in which we may differ are not on the principles but rather on the best way to achieve them.

We are in full agreement with the administration that the competitive marketplace should be the basis of health care cost containment. We are, however, opposed to the administration's proposal for a global budget program implemented through insurance premium price controls.

Far from being an effective solution to cost issues, global budgets and price controls will likely assure that managed competition will fail. Competing accountable health plans are the key and the only real key to a lasting cure to the unacceptable cost spiral.

In significant private investment, we estimate some $100 billion over the next 5 to 7 years will be required to create enough of them and to expand them enough to effect the necessary systemic reform in the health care delivery system.

Price controls will drastically undermine the incentive for such investments and essentially deflect the required private capital.

I am sure that you can understand how capital markets, as well as managed care company boards of directors, would be justifiably leery about investing long term in managed care infrastructure in a price controlled environment.

Further, technical and administrative details of premium price controls would unfailingly be costly. It would establish more bureaucracy and not less.

Further, the data needed to facilitate such an effort is highly questionable at best. Most State-based systems are at least 10 years old.

When all is said and done, recent survey and focus group work reaffirms that not only knowledgeable experts but the broad American public are highly skeptical of the Government's ability to perform a task as complex as regulating one-seventh of the economy for services which are utilized personally by 100 percent of our population.

In addition to the price control problem, I would like to highlight another area of concern in the administration's proposed requirements for health plans.

We certainly agree that all health plans should be certified by government as being able to provide the standard benefit package on a reformed basis.

However, excessive regulatory requirements will serve to impair a plan's ability to compete. Hyper-regulation severely undermines the capacity of health plans to organize themselves to compete in providing cost-effective health care, and it is just that competition on which reform must depend to produce a lasting and successful, affordable quality care system.

In conclusion, we urge the administration and Congress to enact a form of managed competition that will enable a positive and effective competitive market place interaction benefiting the American consumer and not a form that will impose a rigid bureaucratic system in which a too heavy handed government would undermine creativity and beneficial competitiveness.

We appreciate the opportunity to present our views today and continue to pledge to work cooperatively and in a bipartisan manner with both the administration and Congress in pursuit of a lasting and successful reform.

Thank you.

Mr. WAXMAN. Thank you.

[The prepared statement of Mr. Moynahan follows:]

THE ALLIANCE FOR MANAGED COMPETITION

JOHN D. MOYNAHAN, JR.
EXECUTIVE VICE PRESIDENT
METROPOLITAN LIFE INSURANCE COMPANY
ON BEHALF OF THE ALLIANCE FOR MANAGED COMPETITION
MONDAY, NOVEMBER 8, 1993
TESTIMONY BEFORE MEMBERS OF THE HOUSE COMMERCE
HEALTH AND ENVIRONMENT SUBCOMMITTEE

Good morning and thank you for this opportunity to appear before your subcommittee to discuss the major cost containment features of the Administration's program. My name is John D. Moynahan, Jr. I am Executive Vice President for the Metropolitan Life Insurance Company. I'm here today on behalf of The Alliance for Managed Competition, an ad hoc lobbying coalition of five major managed care companies who provide health coverage to over 60 million Americans. Aetna, CIGNA, The Prudential, The Travelers, and MetLife have formed The Alliance with the goal of working effectively towards comprehensive health care reform. We stand ready to work both with Members of Congress and the Administration as we all seek the changes critical to the reform of our nation's health care system.

What The Alliance Supports

We support the Federal enactment of a health care reform bill based on the principles of managed competition. Such a bill would provide the needed structure for a competitive market of private Accountable Health Plans which integrate the delivery and financing of health care. Through its structure and requirements for accountability, managed competition allows competing private programs to bring the creativity, innovation, and consumer responsiveness needed to meet American citizens' expectations for full access to high quality health care they can afford. These Accountable Health Partnerships, and not layers of government regulation,

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will be the true engine of health care reform.

During the last ten years, AMC companies have invested $5.1 billion to establish more than 540 health care networks in about 250 markets across the country. Last year, the member firms of The Alliance paid out more than $55.8 billion in total health benefits. The Alliance companies currently employ some 87,000 workers in all our health benefit programs. Alliance members understand that operating as Accountable Health Partnerships will dramatically change our business. We accept that, are committed to it, and have, in fact, already invested billions in the process of change and reform.

The Alliance for Managed Competition stands committed to the Federal enactment of managed competition, because it is the best approach to benefit the American consumer and results in a number of significant changes:

-- Access to private health care coverage would be significantly improved; limitations would be placed on the use of pre-existing condition clauses; cancellation of coverage because of illness would be prohibited; renewal of coverage would be guaranteed; all plans would guarantee issuance of coverage to all applicants; and individuals could continue standard health insurance coverage in the event of loss of or change in employment.

-- Reliable, accessible, and user-friendly consumer information would be introduced into the marketplace concerning any health plan's pricing, performance, patient satisfaction, and medical outcomes.

-- Consumers would have the ability to change plans during open enrollment periods and would have a wide range of provider choices both within plans and between plans.

-- Greater emphasis on preventive care, including child immunization, would be provided through more effective use of managed care arrangements or Accountable Health Partnerships.

-- Medicaid recipients would be included in the HIPC program and would be advantaged by having access to the same private plans as would other Americans.

-- The collective purchasing power of individuals and small employers in the marketplace would be assured by the creation of Health Insurance Purchasing Cooperatives.

Current Marketplace Cost Containment Initiatives

The Accountable Health Partnerships of the future will be built on the revolution already underway in the marketplace among employers, individuals, providers, and we, the managed care companies, who are reforming the system. This is the market's movement to managed care.

We already see that 51% of employees are in network-based delivery systems, up from 28% in 1988 and almost double the number of four years ago. Enrollment in HMOs has more than quadrupled in the last twelve years and now totals over 41 million Americans nationwide. According to a Foster-Higgins report released in 1993, HMOs cost 23% less than traditional health insurance plans and those costs rise more slowly in managed care. Premium increases were reportedly 26% lower for HMOs than for indemnity plans in 1992. Of large employers surveyed in 1992 by Towers-Perrin, virtually all (91%) say that employee satisfaction with health benefits is the same, or better, under managed care plans.

The Administration's Initiative

The President and First Lady have embarked on a truly historic venture to reform what amounts to 1/7 of the American economy, and we applaud them for their initiative in seeking needed reforms for our health care system. We endorse wholeheartedly the principles that the President embraced in his address before Congress and the nation on September 22 -- security of health

insurance coverage, simplicity for the health care system, savings, choice of providers and plans, quality of care, and individual responsibility. As Congress debates the enactment of health care reform in this session, we believe these principles will, and should, guide that debate. The ways in which we will differ are over how to achieve these principles.

The Administration's Cost Containment Program

We agree with the Administration that the marketplace interaction among cost-effective, quality Accountable Health Partnerships should be the basis of health care cost containment. We oppose, however, the global budget program in the Administration's plan that is implemented through insurance premium price controls.

Far from being an effective solution, we are convinced that this global budget program implemented through premium price controls will assure that managed competition cannot succeed. Significant private investment is required to effect the health care delivery system reforms necessary in this country, almost without regard to the shape reform takes. Price controls will seriously undermine incentives for these investments and effectively serve to deflect them.

For crucial network recruitment and design, information systems, hardware and software, it is estimated that almost $100 billion will be needed over the next five to seven years. With the press reports about potential price controls last winter, nine managed care companies lost over $7 billion in market capitalization in a two-week period, and managed care company boards will be understandably leery about investing in long-term managed care infrastructure in a price-controlled environment.

controlled environment.

Finally, technical and administrative details of premium price controls would be costly. We would be establishing more bureaucracy, not less. Further, the data needed to facilitate such an effort is highly questionable, at best. Most state-based data is at least 10 years old. The 1970s experience shows that there will be a flood of exemptions and exceptions, political favoritism and privileged considerations. Recent focus group work demonstrates that the American public is highly skeptical of the Federal government's ability to perform a task that is as complicated as making thousands of individual price-setting decisions.

Conclusion

We urge the Administration and the Congress to propose and enact a form of managed competition that will enable a positive marketplace interaction benefiting the American consumer and not one in which the heavy hand of government will undermine the creativity and beneficial competitiveness of the private sector. We appreciate the opportunity to present our views today and pledge ourselves to work cooperatively in the pursuit of bipartisan reform with both the Administration and the Congress.

Mr. WAXMAN. Mr. Niemiec.

STATEMENT OF RICHARD M. NIEMIEC

Mr. NIEMIEC. Thank you. I am Richard Niemiec, Vice President for Corporate Affairs for Blue Cross and Blue Shield of Minnesota.

I am here on behalf of the Blue Cross Blue Shield Association. I appreciate the opportunity to testify before you on the important issue of health care cost containment.

We strongly support the President's objectives for health care reform, health coverage for everyone, strict new standards for the insurance markets, and cost containment through managed care networks.

We believe the most effective way to contain costs, while still meeting the needs of patients and consumers, is enactment of reforms that will permit true price competition for the first time in the financing and delivery of health care.

Let me begin by telling you about Minnesota. The Twin Cities area in Minnesota is a local health care market that practices price competition.

Over the past 15 years, premiums in the Minneapolis-St. Paul area have decreased significantly from just above the national average to nearly 20 percent below it. And the employers who move from a fee-for-service carrier to our Blue Plus managed care network experience a minimum 35 percent reduction in premium costs.

We attribute these savings to the use of outcomes-based managed care and database strategies such as small area analysis that identifies communities with abnormally high or low utilization rates, rewarding hospitals for high quality care based on clinical data, and the use of select outcomes-based cardiac network that triples the odds of a favorable outcome.

These examples illustrate successful insurance provider partnerships which identify and promote cost-effective medical practices. Achievement of true price competition requires Federal standards in three areas: insurance reform, cost containment based on informed consumers, and universal coverage.

Insurance reform is desperately needed to assure that every American can get coverage and stop practices that penalize persons who are old or sick.

In addition to important consumer protections, insurance reform will mean that insurers will have to stop competing based on risk selection and start managing costs if they want to compete in the new marketplace.

Second, Federal standards are critical to achieve cost containment. We should define standard benefit packages, lay out for consumers uniform data on quality of care and subscriber satisfaction, and make the tax code changes we believe are important to promote cost conscious decision-making in the purchase of health care services.

We support the President's plans incentives that would encourage managed care networks. Our experience has shown us that it is by far the most effective way of controlling health care costs.

Finally, we believe that if we are to have successful reform, we must cover every American. We believe the best way to achieve

universal coverage is by building on the existing employer-based system.

Two elements in the Clinton plan cause us concern: large regulatory alliances and premium caps. Neither are necessary to achieve the goals of universal coverage and cost containment.

We think the large mandatory alliances proposed by President Clinton and others are unnecessary to achieve reform.

Proponents believe, we think incorrectly, that alliances allow small employers to pool purchasing power to better negotiate rates.

Pooling of risk through community rating would allow everyone to choose health plans based on the best value for the dollar. This can be accomplished without creating a new bureaucratic health alliance.

Finally, the Clinton plan establishes global budgets administered through caps and premiums. We support price competition, not price regulation, and believe that caps are not needed to control costs.

We believe arbitrary premium caps will not work and will be driven by budget priorities and politics having nothing to do with health care.

A global budget would erode service delivery, access to care and quality, threaten the solvency of plans with higher risk subscribers, limit investment in new information systems and capital, and fail to ultimately control spending.

Alliance budgets would be driven by Federal deficit reduction efforts, not by local community needs.

Communities with efficient health delivery systems, such as Minnesota, might be penalized if global budgets are based on historical spending patterns.

Cost containment should, instead, emphasize real competition among plans based on price, quality, and consumer satisfaction.

In closing, I would like to emphasize that we want to work with you in crafting a practical, workable health reform plan and hope that you continue to call on us in any way for help we can provide.

Mr. WAXMAN. Thank you.

[The prepared statement of Mr. Niemiec follows:]

STATEMENT OF RICHARD M. NIEMIEC

Mr. Chairman and members of the subcommittee, I am Richard M. Niemiec, Senior Vice President for Corporate Affairs for the Blue Cross Blue Shield of Minnesota. I am testifying today on behalf of the Blue Cross and Blue Shield Association, the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify before you on the important issue of health care cost containment.

We believe that the best, most effective strategy to contain costs while still meeting the needs of patients and consumers is the enactment of reforms that will permit true price competition--for the first time--in the financing and delivery of health care in this country. Price competition--not health alliances, not price controls--will result in lower costs.

Local health care markets that are leading the country in price competition--such as that in the Twin Cities area in Minnesota--give us insight into how true competition can yield savings and control future cost increases, while maintaining or improving quality of care. The average health insurance premium paid by Blue Cross Blue Shield of Minnesota's subscribers is far below the national average. Over the past 15 years, premiums in the Minneapolis-St. Paul area have gone from above the national average to nearly 20 percent below the national average as the role of price competition among managed care plans has increased. And our actuaries estimate that an employer who moves his or her employees from a fee-for-service carrier to our "Blue Plus" managed care network will experience a minimum 35 percent reduction in premium costs.

Data and outcomes-based managed care are key to these savings. Data-based strategies we use include:

1. Small area analysis. In 1986 our Plan invested in a sophisticated information system--small area analysis--to allow measurement and comparison of the use of health care services across the state. Through this program, we can identify communities with abnormally high or low utilization rates and focus medical review and educational efforts on those areas.

2. Rewarding hospitals for high-quality care. We believe we are the first health plan in the country to reimburse hospitals based on patient outcomes. Using a software program called Medisgroups to collect detailed clinical data from 31 hospitals across the state, we track the outcome of a variety of procedures, compare success and failure rates, and watch for significant variations in patterns of care. A hospital that consistently produces better-than-expected patient outcomes will receive a payment bonus for its high-quality care.

3. Select cardiac care network. On January 1st of this year we launched a pioneer project creating the state's first outcomes-based network for the provision of elective cardiac care. In putting together the network, we issued a detailed request for proposals to cardiac providers in the state and, after review of data on providers' quality of care and patient outcomes, selected ten cardiac care hospitals and their affiliated cardiology groups to participate in the network. The network triples the favorable odds for subscribers undergoing cardiac bypass surgery, with network providers averaging only 15 deaths per thousand compared with 52 deaths per thousand for providers not in the network. Patients treated by cardiac network providers also had far fewer heart attacks

after their surgery--29 per thousand compared with 105 deaths per thousand for non-network providers.

These examples illustrate ways in which insurers--in an effort to control the cost and quality of care--can carefully select providers to participate in their provider networks, and employ improved methods of identifying and promoting cost-effective medical practices. Insurers also can negotiate provider contracts in which providers share financial risk for unnecessary utilization and inefficient use of resources. In communities where price competition is in place, competitive pressures are leading health plans to develop efficient, high-value insurance products.

HOW WE AS A NATION CAN ACHIEVE TRUE PRICE COMPETITION IN THE HEALTH CARE MARKET

In the remainder of my statement, I will review federal standards needed to enable price competition--federal standards to reform the insurance market, permit and encourage comparative shopping by employers and employees, and assure universal coverage. I will close with a brief discussion of why health alliances and global budgets are the wrong solutions for controlling our nation's health care costs.

Federal standards to reform the insurance market. I cannot overemphasize the significant impact insurance market reforms would have on carrier practices and costs. The types of insurance reforms that I will discuss would drive the market toward competition based on price, quality and service, and away from competition based on risk selection. Risk selection undermines true price competition in health care. Under today's rules, it is easier for many insurers and HMOs to hold down costs by screening out high risk subscribers than by managing

overall health care costs. Many insurers, when they have the choice, invest in efforts to avoid high risk subscribers rather than invest in efforts to manage cost.

We believe strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market--and assuring fairness to consumers. Insurance reform would fundamentally change the rules under which insurers operate. New standards for health insurers both would guarantee the availability of insurance for all and bring about real price competition for the first time in the financing and delivery of health care. They would eliminate risk selection as a tool for maintaining competitive prices. Instead, insurers would have to compete on the basis of their ability to manage costs. These standards must be the same in all states.

Federal standards to reform the insurance market should:

1. Require insurers--in an environment of universal coverage--to accept everyone regardless of their health status or employment;

2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;

3. Prohibit insurers from dropping people or groups when someone gets sick, and require insurers to offer continued coverage when a person loses his or her job; and

4. Require insurers to set premiums fairly and not penalize people who are sick or older.

These strict standards must apply not only to insurers and health maintenance organizations, but also to self-funded plans. Self-funded plans must play by the

same rules and be held to the same standards as accountable health plans. These federal standards would require all health plans to compete fairly.

Federal standards to enable and encourage consumers to comparison shop for health coverage. Federal standards also are needed to allow individuals, employers and employees to weigh both price and quality when purchasing coverage.

These federal standards should:

1. Standardize health benefit designs. A limited number of standardized benefit designs would allow consumers to easily compare products, although we do not believe a single standardized benefit design would be workable. These benefit packages should be the same in all states, and should be the same for large and small employers, as well as individuals and families who do not purchase coverage through an employer.

2. Provide consumers with standardized data on a health plan's quality of care and subscriber satisfaction rating. Standardized measures of quality and subscriber satisfaction would enable consumers to select a health plan based on quality and service, in addition to price. To hold administrative costs to a minimum and enable more meaningful comparisons, the federal government should develop standard measures that could be adopted by the states.

3. Limit the federal tax deductibility for employers--and the tax exemption for employees--of employer contributions for health benefits. Changes in the tax treatment of employer contributions for health benefits would strengthen the incentives for employers, employees and individuals to weigh price more carefully when selecting a health plan. As price becomes more important to

employer and employee consumers, health plans would make greater efforts to find more effective ways of managing costs.

Federal standards to assure universal coverage. True competition requires universal coverage in order to eliminate adverse selection by consumers and risk selection by insurers. Insurance reform would improve access to coverage, but it would not lead to universal coverage. A requirement for employers to offer and contribute to the cost of health benefits, and for individuals to accept and pay for the balance of the premium, is necessary to achieve universal coverage.

WHY ALLIANCES ARE NOT NEEDED TO CONTROL COSTS

Some "managed competition" proposals, including that of President Clinton, call for large, mandatory alliances to allow small employers and individuals to "pool their purchasing power" and negotiate a better deal with insurers. We believe this is the wrong prescription for the problem, and that mandatory alliances should not be included in reforms that are finally enacted.

Pooling of risk--through community rating--would allow small employers with older employees or employees with serious health problems to obtain affordable insurance for the first time. Guaranteed issue, and the other new standards for health insurers reviewed earlier in this statement, would allow these employers to choose any health plan offered in their community. And community rating would allow all employers to compare the premiums charged by every health plan and select the plan that offers the best value for the money. All of this can be accomplished without creating a new, bureaucratic health alliance.

WHY GLOBAL BUDGETS ARE NOT NEEDED TO CONTROL COSTS

The President's proposal calls for global budgets, administered through caps on premiums, as a "back-up" strategy to control costs. We believe that caps are not needed to control costs, and should not be included in the reforms that are finally enacted.

Never before has the federal or any state government imposed an industry-wide ceiling on private spending, and for good reason. A global budget for health care costs administered through premium caps would result in a number of unintended, negative consequences for health plans, providers, and ultimately, consumers. In addition, implementation would be problematic--if not impossible--in the foreseeable future.

A global budget would erode service, access to care and quality, threaten the solvency of health plans with higher risk subscribers, and fail to control spending for the following reasons.

1. Global budgets enforced through premium caps are price controls, and price controls have never worked.

2. Health plans that must cut their premiums to live within the arbitrary budget may be driven to "quick fixes" in an effort to meet their caps. These fixes might include the downsizing of provider networks, leading to longer waiting lines, lower consumer satisfaction, and rationing of access to services.

3. Alliance budgets would be driven by the need to reduce the federal deficit, not by local community needs. The federal government would subsidize the costs of coverage for many employers, as well as low-income individuals and families. An increase in the premium for the standard benefits package would

increase the cost of these federal subsidies. Pressure to hold down the deficit would lead to strong pressures to cut Alliance budgets. As a result, community health care needs might be compromised.

4. Health plans subject to an arbitrary premium cap would be unable to make the investments in new information systems needed to encourage cost-effective practices and improved patient outcomes. They would also be unable to make the investment in "bricks and mortar" that health care systems such as HMOs require.

5. Premium caps would undermine the financial stability of some health plans and may drive "good" health plans with excellent consumer records into insolvency. Consumers whose health plans are financially unable to pay claims would not feel as if reform brought them the "security" that was promised.

Furthermore, the difficulty of setting and enforcing global budgets and premium caps should not be underestimated. Setting budgets for each Alliance would either redistribute tens of billions of dollars among Alliances in an effort to even out differences in spending for personal health services, or freeze those differences in place -- whether warranted or not. Communities that have efficient health delivery systems, such as Minnesota and Rochester, would suffer disproportionately under a premium cap. Local needs may be overshadowed by national political pressures. The best method for determining how much should be spent on health care in a community is real competition among plans serving the community based on price, quality, and consumer satisfaction.

SUMMARY

We believe that price competition is the best, most effective strategy to contain costs while still meeting the needs of consumers. We support the enactment of reforms that will permit true price competition--for the first time--in the health care market; we support federal standards to reform the insurance market, permit and encourage comparative shopping by employers and employees, and assure universal coverage. Price competition--not health alliances, not price controls--will result in lower health care costs.

Thank you for this opportunity to present our views before the Subcommittee.

Mr. WAXMAN. Mr. Havens.

STATEMENT OF SAMUEL HAVENS

Mr. HAVENS. Thank you, Mr. Chairman. My name is Sam Havens, Senior Vice President of Prudential and Chairman of the Board of Group Health Association of America, GHAA.

I am here today on behalf of the GHAA which represents 347 health maintenance organizations whose 32 million enrollees account for about 75 percent of the total national HMO enrollment.

GHAA supports the goals of health care reform, and we are pleased that HMO's are being given a central place in the health care reform debate.

It is our conviction that expansion of well-structured, fiscally sound managed care options can play a major role in providing comprehensive, high-quality health care at an affordable cost to all Americans.

However, we are concerned that these goals could be undermined by the use of global budgets and price controls to constrain health care costs.

Regulatory cost containment initiatives could thwart the future development of HMO's and other systems that integrate the financing and delivery of health care. They may end up penalizing efficient plans. HMO's which have already eliminated some of the waste from their health care delivery systems will find it much harder to meet arbitrary premium caps than less-efficient plans that are likely to have more flexibility in adjusting their premiums.

Premium caps present an additional problem for managed care plans, that is the ability of health plans to raise capital.

Existing and start-up health plans will require large infusions of new investment capital if they are to meet the needs of the proposed universal health security system. While facility-based group and staff model HMO's have the most obvious capital needs, expansion of IPA and network model plans require substantial capital as well.

The former plans have a greater proportion of their assets in property and equipment since they are most likely to own their own medical buildings and equipment. The latter must make substantial investments to create the administrative infrastructure and sophisticated management information systems necessary for their success.

Experience to date, with all forms of regulatory cost controls, whether simple or complex in design, suggest that they are, at best, crude instruments with which to contain costs and, at worse, may be explicitly counterproductive.

It is our concern that such controls and the shape they may take will negatively impact the plans that are the foundation of a reformed health care system.

In our experience, the use of premium caps to bring down the rate of growth in premiums down to the CPI by 1999 is unrealistic and unattainable. There is, however, an incredible amount of innovation going on in the private sector. This can be enhanced by health care reform.

Physicians in hospitals are forming new alliances, primary care based group practices are forming at a rapid rate, many employers

have become sophisticated purchasers of health benefits. Both consumers and purchasers are now actively seeking better information upon which to base their coverage choices. And HMO growth is continuing at an impressive rate.

I have recently seen changes in the health care system that seemed impossible 20 years before. I invite all members of the committee to visit the HMO's in their districts and to witness this change firsthand.

We at GHAA look forward to working with the committee.

Mr. WAXMAN. Thank you Mr. Havens.

[The prepared statement of Mr. Havens follows:]

STATEMENT

ON BEHALF OF

GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. Chairman and members of the Subcommittee, I am Samuel Havens, Senior Vice President of The Prudential Insurance Company of America, Inc., and Chairman of the Board of Group Health Association of America, Inc. (GHAA). I am here today on behalf of GHAA which represents 347 health maintenance organizations whose 32 million enrollees account for about 75 percent of the total national HMO enrollment.

GHAA supports the goals of health care reform, and we are pleased that HMOs are being given a central place in the health care reform debate. It is our conviction that expansion of well-structured, fiscally-sound managed care options can play a major role in providing comprehensive, high quality health care at an affordable cost to all Americans. However, we are concerned that these goals could be undermined by the use of global budgets and price controls to constrain health care costs.

We want to emphasize that while much of the impetus for reform comes from the need to reduce the inordinately high rate of increase in overall health care costs, an even greater emphasis on assuring appropriate care and on maintaining and continuously improving the quality of care will be necessary if reform efforts are to succeed. HMOs meet both of these objectives by combining the financing and delivery of health care.

Quality and Appropriate Care

We are convinced that the cost of health care can be contained over the long term only by changing the structure of the current system to promote competition on the basis of both quality and cost effectiveness. It is on this basis that HMOs have achieved their success.

While maintaining their focus on the continuous improvement of the quality of care that they provide, HMOs have become increasingly popular with employers due to their ability to control costs. Not coincidentally, where HMO penetration is highest, more signficant moderation of cost increases has been seen. Studies such as those by James C. Robinson published in the Journal of the American Medical Association on November 20, 1991, ["HMO Market Penetration and Hospital Cost Inflation in California, JAMA 266(19): 2791-2723] and W. Pete Welch published by The Urban Institute in March, 1991, ["HMO Market Share and Its Effect on Local Medicare Costs] have found that the greater the HMO penetration and hospital competition for HMO and PPO business, the lower the rate of increase in health care costs overall.

KPMG Peat Marwick recently reported a significant departure from years of double digit increases in the rate of overall premium growth: 8 percent in 1992-93 down from 11 percent in 1991-92. As a primary reason for this decrease, the firm cites the growing maturity of managed care and utilization management which it credits with changing the environment in which

physicians and other providers deliver care. If enrollment in HMOs and other managed care options increases under health care reform as many anticipate, the positive impact of HMO practice patterns and quality assurance initiatives will grow accordingly.

Consumer satisfaction with HMOs has been demonstrated by their impressive growth over the past decade. Membership has increased from 10 million enrollees in 1982 to 41 million enrollees in 1992. A recent consumer satisfaction survey conducted by National Research Corporation of Lincoln, NE, and reported in the December 14, 1992, issue of Modern Healthcare magazine showed that HMOs enrollees are, on average, more satisfied with their health plans than consumers with PPO or indemnity coverage.

Studies of quality, such as that which appeared in the Annals of Internal Medicine in September, 1991, [Steven Udvarhelyi, et al, "Comparison of the Quality of Ambulatory Care for Fee-for-Service and Prepaid Patients," Annals of Internal Medicine 115(5):394-400] have shown consistently that quality of care in HMOs is equal to or better than that in the fee-for-service sector. Because HMOs care for an enrolled population, they have the capability to systematically enhance quality through internal quality improvement systems. Their access to detailed information on services provided allows HMOs to analyze the care and implement appropriate guidelines to improve outcomes. Further, drawing upon this information, HMOs in partnership with private sector employers are now in the

forefront of efforts to develop performance measures and provide better and more useful information to consumers through projects such as the development of HEDIS 2.0, which contains over sixty standardized health plan performance measures related to quality, enrollee access and satisfaction, utilization and financial data and is designed to provide standardized information on the quality and performance of HMOs and similar managed care systems.

All of the major quality enhancement initiatives recommended in the Administration's proposal -- practice guidelines, outcomes measurement and increased emphasis on preventive care -- are a traditional part of an HMO. These initiatives contribute to cost effectiveness and quality of care by eliminating or drastically decreasing unnecessary services and by providing for more appropriate care at early stages of illness and for access to preventive care.

Premium Caps/Capital

Regulatory cost containment initiatives can thwart the future development of HMOs and other systems that integrate the financing and delivery of health care. A major concern for HMOs is the negative impact of premium caps on the ability of health plans to raise capital. Many health plans will require large infusions of new investment capital if they are to meet the needs of the proposed universal health security system. While facility-based group and staff model HMOs have the most obvious

capital needs, expansion of IPA and network model plans requires substantial capital as well. The former have a greater proportion of their assets in property and equipment since they are more likely to own their own medical buildings and equipment. The latter must make a substantial investment to create the administrative infrastructure and sophisticated management information systems (MIS) necessary to their success. In addition, we anticipate that health plans will be required to expend substantial resources to meet new national data requirements. Health plans should be free to build into their rates adequate allowances to support anticipated capital needs and to maintain the fiscal strength to attract needed capital. The limitations imposed by premium caps will divorce rate setting from these important needs.

Premium Caps/Efficient Plans

Premium caps present an additional problem for managed care plans. HMOs, which have already eliminated some of the waste from their health care delivery systems, will find it much harder to meet arbitrary premium caps than less efficient plans who are likely to have more flexibility in adjusting their premiums, because they have more waste to eliminate.

Indeed, the achievement of high quality with ever greater efficiency is a constant challenge and would become even more so in an environment with cost controls. HMOs have achieved cost savings by improving the coordination and appropriateness of

care, negotiating favorable rates with hospitals and providers, and avoiding unnecessary hospitalizations. As discussed in a recent article by Jack A. Meyer and Ingrid Tillmann in Managed Care Quarterly, HMOs and other managed care entities have become dedicated to continuous quality improvement and are reducing inappropriate practice variation; improving management of high cost patients and conditions, sometimes through expanded packages of services which are expected to yield long-term savings; and examining patterns of care in relation to health outcomes and continually feeding back information to providers.

Experience with Cost Controls

Experience to date with all forms of regulatory cost controls, whether simple or complex in design (as in the unit price controls under the Nixon administration or the DRG and RBRVS mechanisms of the current Medicare program), suggests that they are at best crude instruments with which to contain costs, and at worst they may be explicitly counterproductive. It is our concern that such controls and the shape they may take will negatively impact the plans that are the foundation of a reformed health care system.

Global Budgets

The Administration's proposal calls for the National Health Board to establish a "national per capita baseline premium target" which is based upon a determination of the total

expenditures in 1993 for services covered under the comprehensive benefit package. Regional alliance premium caps are built upon this foundation with annual indexing to bring the rate of growth in premiums down to the rate of growth in the CPI by 1999. Many noted economists have argued that the link to the CPI is unrealistic and unattainable.

The baseline premium target does not incorporate all of the increased costs which must be borne by health plans under the Administration's proposed legislation. For example:

- health plans in a regional alliance may be assessed up to 2 percent of the total premiums paid by those enrolled through the alliance to cover outstanding liabilities in the event of a health plan insolvency;

- health plans will continue to bear the impact of cost shifting because of shortfalls in payments on behalf of Medicaid beneficiaries, the cap on subsidies available to low-wage and small businesses, and because they are prhoibited from disenrolling members for nonpayment of premiums;

- health plans may be required to expend substantial resources to meet national data requirements; and

- since the point of service coverage which must be offered by plans offering the "low cost sharing schedule" differs substantially from current HMO point of service offerings -- which generally provide for a deductible and higher cost sharing for out-of-plan use -- it remains unclear whether premiums for this option will be high enough to cover the combination of in-plan and out-of-plan utilization.

An additional design problem with the baseline target amount is that it institutionalizes current geographic variations in health expenditures. High cost areas in which a signficant cost factor may be overutilization will remain relatively high cost areas. Low cost areas, such as medically underserved rural

areas, will not be given sufficient room for growth in premiums to improve accessibility to needed care.

In conclusion, the most troublesome problem with premium caps is that they will inevitably serve as a serious impediment to the primary goal of health care reform -- the alteration of marketplace incentives to bring about the delivery of high quality, affordable health care. While the establishment of targets against which the success of reform can be measured may be useful, the imposition of caps from the outset may mean that a market-based system is never put to a true test of its effectiveness.

The innovation in the private sector that has been sparked by the prospect of health care reform and that is distinguished by a dual emphasis on quality and cost effectiveness deserves encouragement. Physicians and hospitals are forming new alliances; providers are increasingly affiliating with managed care organizations; many employers have become sophisticated purchasers of health benefits; both consumers and purchasers are actively seeking better information on which to base their coverage choices; and HMO growth is continuing at an impressive pace.

It is critical to the success of health care reform that marketplace innovation and the demonstrated success of HMOs in achieving the central goals of reform, delivery of comprehensive, high quality, affordable health care services to all Americans, be encouraged. We look forward to working with you as action on reform legislation proceeds.

Mr. WAXMAN. Ms. Green.

STATEMENT OF KYLANNE GREEN

Ms. GREEN. Thank you, Mr. Chairman and members of the committee. I am Kylanne Green. I am the Director of Managed Care for the Health Insurance Association of America.

The HIAA represents about 270 of the commercial insurers of this country and cover about 65 million Americans. I am pleased to have the opportunity to speak to you this afternoon.

Currently, health care spending is 14 percent of our Gross Domestic Product. Unless there are changes, spending on health could reach 19 percent of the GDP by the year 2000.

Health care costs are the primary reason that millions of Americans do not have health insurance. With approximately 37 million Americans without health insurance and health care costs, consuming an even greater share of our GDP, there can be no question regarding the imperative for comprehensive health care reform. And reform must focus on cost containment in order to achieve the goals of savings and security.

In its vision for reform, the HIAA has proposed specific means to help contain costs. We believe these are critical to any successful reform proposal.

I would first like to address the issue of health care fraud. HIAA believes that the savings from anti-fraud activities are significant. Data show that each year Americans lose 10 percent of total health care expenditures to fraud and abuse. That translates into an annual loss of $80 billion.

A recent survey on anti-fraud activities conducted by HIAA revealed that the number of fraud cases investigated by health insurers increased by more than 75 percent in the last 2 years. And during the same period, insurers reported a 150 percent increase in net savings from fraud investigations. For every dollar that the insurers spend in anti-fraud programs they save nine.

The Health Insurance Association of America believes that President Clinton's plan to combat fraud and abuse in health care is going to assist them in investigating and prosecuting fraud.

In particular, the strengthening of Federal penalties for those convicted of fraud, anti-fraud standards for electronic media claims, and increased government funding for anti-fraud enforcement is going to help insurers.

At the same time, we think that to step anti-fraud activities up, we need to concentrate on making other administrative functions more effective. We recognize that all administrative processes in the health care industry must be streamlined, and we are committed to working with others in the industry to increase standardization.

We have been participating in the Work Group for Electronic Data Interchange since its inception in 1991. We support all of its recommendations. We believe EDI, which we commonly refer to as the paperless claim system, can greatly improve information exchange among all the players of the health care industry.

The benefits include better, more efficient communication, improved patient care, and lower administrative costs.

The HIAA believes the President's plan pertaining to administrative simplification will go a long way toward reducing administrative costs. We agree with the President, our health care system is awash in a sea of paper. We commend the President's recommendations for standardization of reimbursement forms, the automation of insurance transactions, and the streamlining of Medicare.

The costs of medical liability also add significantly to the Nation's health care costs. Physicians pay over $5 billion annually in medical liability insurance premiums. Perhaps just as striking are some of the hidden costs associated with the practice of defensive medicine by providers that are threatened by lawsuits.

Although there is lot of disagreement about the actual cost of defensive medicine, there are some studies that put it as high as $36 billion that could be saved in a 5-year period of time if we were to eliminate defensive medicine practices. The HIAA supports Federal medical malpractice reforms that are going to reduce the incidence of malpractice by improving risk management, recognizing the use of national practice guidelines as a valid defense against malpractice claims and the better policing of health care delivery.

We are pleased that the President has proposed an alternate dispute resolution mechanisms. We have concerns, however, about the potential cost of his proposed State enterprise liability demonstration projects.

The HIAA believes that changing the health care delivery system is fundamental to reform. The delivery of care must be substantially better integrated and organized than it is today to meet the needs of consumers and providers.

We think that managed care provides such integration and organization and should be the primary vehicle for sustained systemwide cost savings.

Because prevention promotes health and minimizes health care costs, the HIAA regards preventive services as essential components of health care. We applaud the inclusion of preventive services as an essential benefit under the President's plan.

No degree of access to medical services, however, and no advances in medical technology can substitute for healthful lifestyles. The HIAA believes that Americans must be rewarded for assuming individual responsibility for their own health. People who engage in healthy behavior should not be asked to pay the same insurance premiums as those who do not.

We support the use of financial incentives for individuals to engage in healthy lifestyles, and we are opposed to the President's proposal for pure community rating.

Another aspect of individual responsibility is informed decisionmaking. Consumers must be educated about how best to use the health care system. They should have the opportunity to consider economics when choosing providers and services. This can only be accomplished if they have access to useful information.

HIAA supports establishing standards for reporting health outcomes and cost information.

Mr. WAXMAN. Thank you very much, Ms. Green. The rest of that statement will be part of the record.

[Testimony resumes on p. 267.]

[The prepared statement of Ms. Green follows:]

STATEMENT OF KYLANNE GREEN, DIRECTOR, MANAGED CARE

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Kylanne Green. I am the Director of Managed Care for the Health Insurance Association of America (HIAA) which represents approximately 270 commercial insurers covering approximately 65 million Americans.

As you know, since the early 1980s, health care inflation has been nearly double that of the Consumer Price Index. Currently, health care spending is 14 percent of our Gross Domestic Product (GDP), and, unless there are changes, spending on health care could reach 19 percent of the GDP by the year 2000. With approximately 37 million Americans without health insurance coverage, and health care costs consuming an ever greater share of our Gross Domestic Product, there can be no question regarding the imperative for comprehensive health care reform. And, reform must focus on cost containment in order to achieve the goals of savings and security.

PRICE CONTROLS AND PREMIUM CAPS

While the Health Security Act does not contain the words "National Health Care Budget," the notion of capping health care spending is contained all through the Administration's document. [See attached document "Budget Development and Enforcement (Premium Caps) For Regional Alliances in President Clinton's Proposed Health Security Act"] There is no question that health care cost growth needs to be curbed. HIAA believes there are many ways to cut costs without cutting care. However, arbitrary price controls have never worked in our economy. The Health Security Act (Title VI, Subtitle A) directs the new National Health Board to set a baseline premium target for 1995. It then sets a national and local inflation factor for premiums in subsequent years. The inflation rate for premiums would be limited to no more than the CPI by 1998.

The HIAA commissioned the Washington National Tax Services of Price Waterhouse to compare the premium growth targets in the Administration's health care proposal and the actual growth in real per capita health care spending in twenty-four Organization of Economic Cooperation and Development (OECD) countries between the period of 1961 and 1991. Only four countries -- Turkey, Ireland, Sweden, and Greece -- held per capita health spending to a level that was comparable to CPI growth for one of the five-year intervals since 1961. Most countries have had rates of growth that are well above the rate of general inflation. In fact, during the most recent five-year period, three out of four OECD countries had growth rates that averaged 2.1% higher than the rate of growth in the general price level.

Considering the dramatic growth in health care costs is only partially related to prices (no more than one-third), such a target would be difficult to achieve without radically affecting either the benefits or the services which people receive. The lion's share of health care cost growth is attributable to growth in the use of health care services and the ever-increasing

availability of new procedures and services. CBO issued a study last month questioning the efficacy of premium controls, saying they would have "undesirable consequences" such as "technological progress in health care would probably occur more slowly." "Effective limits on premium increases would affect both the quantity and quality of health insurance coverage available to consumers and their future access to new medical technologies."

Henry Aaron and Charles Schultze of the Brookings Institution have noted:

> "Growth of medical costs will be contained on a sustained basis only if we are prepared to ration care to those who are insured and are able and willing to pay for services... Concern for fundamental values such as age, visibility of an illness, and aggregate costs of treatment will inevitably shape our decisions on resource allocation. Physicians and other providers will increasingly experience tension between their historic commitment to doing all that is medically beneficial and the limitations imposed on them by increasingly stringent cost limits."

In the October issue of Science, Eleanor Chelimsky states that:

> "Two other readily foreseeable effects of cost reduction on access and quality are the decrease in the amount of time physicians and surgeons can spend with patients, as well as a concomitant decrease in the number of real physician services per visit; and a corresponding increase in patient waiting time and in the number of visits required for appropriate medical care to take place."

As a country, we must decide if we are ready to ration access to health care for the American consumer. The budget and premium caps set forth in the President's plan will move us in that direction.

Implementing the President's plan will require significant new capital investment. Private estimates of new capital requirements vary all over the lot. The lowest we've seen is $30 billion over the phase-in period. The highest is $90 billion. Needless to say, neither is a trivial sum. But, there will be no incentive for private investment. In a price controlled/premium capped market, companies will be severely impaired in their efforts to attract capital. Capital will be needed to organize the networks of hospitals, doctors, and other providers that are the core of the new system. Capital is needed to assure that health plans have adequate reserves to cover unexpected losses and guarantee solvency. The new system will require more capital than the current system, both to cover the 37 million uninsured, and to cover the many millions of employees who will have to shift from self-insured employer plans to fully insured plans offered through the health alliance system. Most self-insured

plans are not likely to have any significant reserves to offset capital requirements. These capital requirements raise great concern about the solvency of health insurers. Over the last decade, the profit margin of the health insurance industry has averaged 1.75% [see attached chart]. With that narrow margin, if the premium cap is set too low and carriers are unable to cover submitted claims, insolvencies will occur.

The HIAA has proposed specific means by which a reformed health care system can contain costs. In its Vision for Reform, the HIAA embraced seven mechanisms to help contain costs. We believe these mechanisms are basic to reform:

- increased activity to combat fraud and abuse
- administrative simplification
- control of malpractice costs via medical liability reform
- increased reliance on managed care
- emphasis on personal responsibility and incentives for health lifestyles
- emphasis on prevention
- better access to management information

FRAUD AND ABUSE

We believe that the savings from anti-fraud activities are significant and warrant the insurance industry's continued vigilance. Each year we lose 10 percent of our total health care expenditures to fraud and abuse. That translates into an annual loss of nearly $80 billion. If we stopped payment on $80 billion in fraud, we could provide more than $2,000 in health insurance to every American who currently has no coverage.

A recent survey on anti-fraud activities conducted by the HIAA revealed that the number of fraud cases investigated by health insurance companies increased by more than 75 percent in the last two years. During the same period, insurers reported a 150 percent increase in net savings from fraud investigations. For every dollar insurers spent in anti-fraud programs, they saved nine dollars. Two thirds of the reported savings from anti-fraud activities came as a result of detecting fraudulent cases before any payment is made.

HIAA believes that President Clinton's plan to combat fraud and abuse in health care will assist insurers in investigating and prosecuting fraud cases. In particular, the strengthening of federal penalties for those convicted of fraud, anti-fraud standards for electronic media claims, and increased government funding for anti-fraud enforcement will help insurers. In addition, the HIAA would like to see broad civil immunity that would enable insurers to share information about providers suspected of fraud.

ADMINISTRATIVE SIMPLIFICATION

HIAA recognizes that all administrative processes in the health care industry must be streamlined. We are committed to working with others in the industry to increase standardization. HIAA participated in, and wholeheartedly supports the recommendations of the Work Group for Electronic Data Interchange (WEDI).

We believe that electronic data interchange (EDI), commonly referred to as a "paperless claims system" can directly improve information exchange among all of the players in the health care industry. The benefits of EDI include better, more efficient communication, improved patient care, and lower administrative costs. As the insurance industry has become more sophisticated and more responsive to the marketplace, EDI usage has increased.

HIAA believes the President's plan pertaining to administrative simplification will go a long way toward reducing administrative costs. We agree with the President; our health care system is awash in a sea of paperwork. We commend the President's recommendations for the standardization of reimbursement forms, the automation of insurance transactions, and the streamlining of Medicare.

MEDICAL LIABILITY REFORM

The costs of medical liability add significantly to the nation's health care costs. Physicians pay over $5 billion in medical liability insurance premiums annually. Even more striking are the "hidden" costs associated with the practice of "defensive medicine" by providers threatened by lawsuits. A recent study found that the health care system could save $36 billion over five years by eliminating defensive medicine practices. Medical liability affects more than just providers in the health care system. Liability costs also increase the cost of pharmaceuticals and medical devices. All of these costs are passed on to consumers.

HIAA supports federal medical malpractice reforms that will reduce the incidence of medical malpractice by improving risk management, recognizing the use of national practice guidelines as a valid defense against malpractice claims, and better policing of health care delivery. The HIAA would also like to see limits on extra contractual damages. We are pleased that the President has proposed an alternative dispute resolution mechanism, but we have concerns about proposed state enterprise liability demonstration projects.

MANAGED CARE

HIAA believes that changing the health care delivery system is fundamental to reform. The delivery of care must be substantially better organized than it is today to meet the needs

of consumers and providers. We believe that managed care can be a primary vehicle for achieving sustained system-wide cost savings.

A recent GAO Report concluded that there is insufficient evidence to demonstrate that managed care controls costs. The Health Insurance Association of America has reached a different conclusion. We believe that the success of managed care in the marketplace clearly demonstrates the value of managed care. In the last decade, enrollment in network based managed care has grown from a market share of 6 percent to 42 percent. The principal reason for this growth is that employers believe that managed care can help control their health care costs.

In addition, to growing popularity, there has been research that proves cost savings. From over two decades of studies by such noted researchers as the Rand Corporation and Hal Luft, there is convincing and consistent evidence that group and staff model HMOs reduce hospital use and costs by as much as 25 percent. These studies also found that the quality of service in the HMO was equal to the traditional fee-for-service systems with which it was compared.

Managed care systems should be permitted to pay providers in such a way to encourage quality and cost effectiveness. Providers should share in the risk of the cost of providing care, and should be rewarded for the cost-effective use of medical resources. New payment systems should be developed that encourage provider autonomy in decision making and reduce the micro-managing of providers that exists today.

Better relationships between providers and insurers will promote: enhanced financial and managerial interactions, timely and responsive service to consumers and providers, quality management programs, and fraud and abuse prevention. The emphasis that managed care places on efficiency in the health care system should be reflected in the government's promotion of Medicare and Medicaid beneficiaries' participation in managed care.

PREVENTION

Because prevention promotes health and minimizes health care costs, the HIAA regards prevention as an essential component of health care reform. We applaud the inclusion of preventive services as part of the comprehensive benefits package in the President's plan.

Although improved coverage for preventive services will likely increase immediate demand for those services, demand for more intensive services will decrease long term. HIAA believes that coverage for preventive services is a long term investment that will benefit both the health of our nation's citizens and lower overall health care costs. For example, in a 1991 report to the

Committee on Ways and Means, there are findings that for children under the age of 18, the uninsured reported 46 percent more hospital days per capita than the insured. There is a clear link between coverage for preventive services and primary care and decreased use of more intensive services.

INDIVIDUAL RESPONSIBILITY

No degree of access to medical services and no advances in medical technology can substitute for healthful lifestyles. We know that smoking is one of the single most preventable causes of death in the United States today. It is estimated that smokers experience $6,239 more in expenditures on medical care over the course of a lifetime than non-smokers. Unhealthy lifestyles, violent crime, substance abuse, poor nutrition, unsafe living conditions, and the breakdown of families all contribute to health care costs.

HIAA believes that Americans must be rewarded for assuming individual responsibility for their own health. We support the use of financial incentives for individuals to engage in healthy lifestyles and are opposed to the President's proposal for pure community rating. Community rating will increase premiums for younger, healthy workers and low-risk people who make healthy lifestyle choices. Why should those who exercise regularly and don't smoke pay more for their coverage to subsidize those who smoke two packs per day?

BETTER ACCESS TO MANAGEMENT INFORMATION

Another aspect of individual responsibility is informed decision making by consumers. Consumers must be educated about how best to use the health care system, and individuals should have financial incentives to consider cost when choosing providers and using services. They must be informed decision makers. This can only be accomplished if they have access to useful information. HIAA supports the establishment of standards for the reporting of outcome and cost information. HIAA also supports the establishment of a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis. Dissemination of this information will: assist health plans in controlling costs and utilization, help managed care systems produce and evaluate outcome and cost data, and help a government-authorized entity develop guidelines that ensure that providers set consistent payment levels.

The information systems required to compile this data are extensive and will require significant new capital investment. In effect, in order to save money, insurers will have to spend money. While HIAA agrees with the President's proposal to enhance access to health care management information, we have serious concerns about whether, in a premium capped environment, insurers will be able to generate this significant new capital.

Under the President's plan, premiums will be limited at the same time new and unpredictable demands are being made on health plans and insurers.

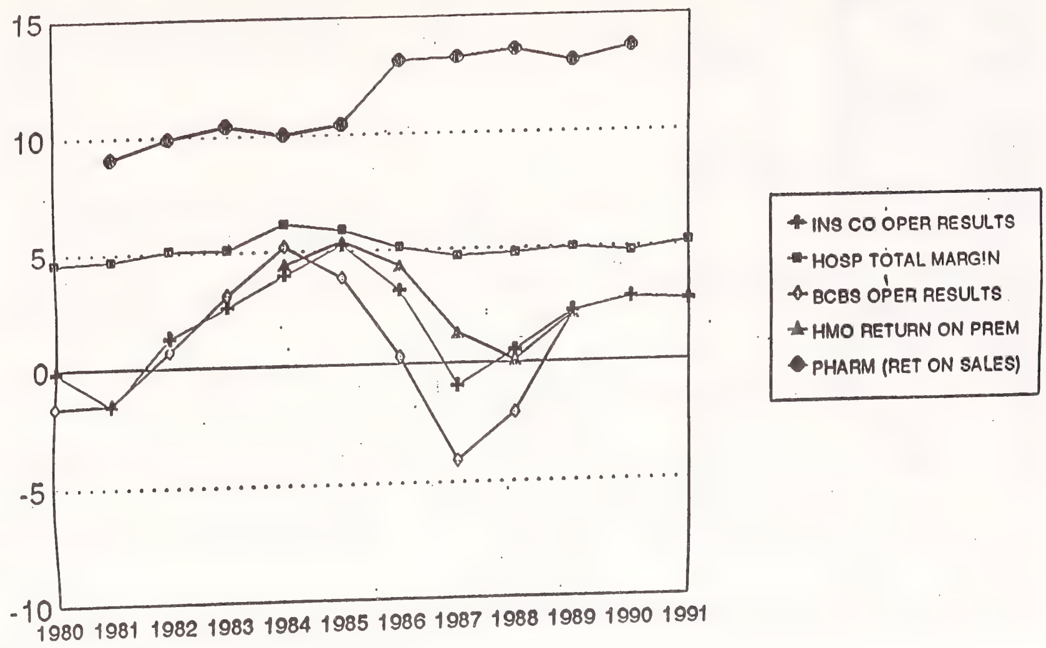
CONCLUSION

In conclusion, I want to emphasize that the HIAA wants to be a responsible participant in the national health care debate. We want reform which provides universal coverage, promotes cost containment, encourages individual responsibility, preserves choice, and maintains the quality of our health care system. We look forward to working with Congress and the Administration to achieve these mutual goals.

HEALTH INSURANCE ASSOCIATION OF AMERICA

WHAT WE ARE FOR	WHAT WE ARE AGAINST
Cradle to grave health insurance core benefits for all Americans.	Price controls on insurance.
Mandate that individuals be covered and pay towards coverage (only if financially able).	Exclusive (monopoly) health alliances.
Mandate employers pay towards coverage (only if financially able).	Pure community rating.
Insurers do not underwrite "take all comers."	
No pre-existing conditions.	
No fear of loss of coverage.	
Tax bargain capped at core benefit.	
Managed care -- further development to control both volume and price.	
Remove state law barriers that interfere with managed care.	
Put Medicaid and Medicare covered individuals under managed care.	
Publish price and quality outcome data from all managed care organizations.	
Professionals develop practice guidelines -- safe haven from malpractice and better educates the physicians on what works.	
Tort reform.	
Electronic data interchange of information and a single universal claim form.	
Individuals personally responsible for their health.	
Move away from sickness and repair toward wellness and health.	
Incentives for healthy lifestyles.	
End cost shift from Medicaid and Medicare to private insurance patients.	
Change societal attitudes as to the end of life so death is not an exercise in invasive technology.	

PROFITABILITY OF SELECTED SECTORS IN THE HEALTH CARE AND HEALTH INSURANCE INDUSTRIES 1980-1991



TRENDS IN PROFITABILITY FOR SELECTED SECTORS IN THE HEALTH CARE AND HEALTH INSURANCE INDUSTRIES, 1980–1991

Year	(1) Insurance Company Operating Results (% of Prem)	(2) Hospital Total Revenue Margin (% of Tot Rev)	(3) Blue Cross Blue Shield Operating Results (% of NSR)	(4) HMO Return on Premium (Net Gain as % of Earned Prem)	(5) Pharmaceutical Manufacturers Return on Sales (Median %)
1980	(0.2)	4.6	(1.6)		
1981	(1.6)	4.7	(1.5)		9.1
1982	1.3	5.1	0.7		9.9
1983	2.6	5.1	3.1		10.4
1984	4.0	6.2	6.2	4.4	10.0
1985	5.3	5.9	3.8	5.4	10.4
1986	3.2	5.1	0.3	4.3	13.1
1987	(0.9)	4.7	(4.1)	1.3	13.2
1988	0.5	4.8	(2.1)	0.1	13.5
1989	2.2	5.0	2.1	2.1	13.0
1990	2.8	4.8			13.6
1991	2.6	5.2			

(1) HIAA survey of its top 20 members.
(2) AHA Hospital Panel Survey.
(3) Blue Cross Blue Shield net subscription revenue.
(4) McKinsey & Company, Health Care Payor Annual.
(5) Fortune Magazine, various issues.

A Budget by Any Other Name: A Before-and-After Comparison

Feature	Working Group Draft*	Health Security Act
Draft uses term "National Health Care Budget"	Yes p. 93	No
Act sets annual rate-of-increase limits for premiums	Yes p. 94	Yes §6001 (a)
National Health Board (NHB) sets per capita premium target for each regional alliance (RA)	Yes p. 95	Yes §6003
Health plans bid and negotiate with alliances, which report final bids to NHB	Yes p. 95	Yes §6004 (a,b)
Alliance's weighted average premium must not exceed target	Yes p. 95	Yes §6004 (c,d)
If exceeded, NHB/RA reduce payments to plan whose premiums are over target	Yes p. 96	Yes §6011
Plans, in turn, reduce payments to providers	Yes p. 96	Yes §6012

* Page numbers are for the 9-7-93 Working Group Draft, the 239-page, 8 1/2" x 11" version, rather than the published book version.

HIAA

Health Insurance Association of America

November 3, 1993

Budget Development and Enforcement (Premium Caps) For Regional Health Alliances in President Clinton's Proposed Health Security Act

1. The National Health Board (NHB) determines a "national per capita baseline premium target" for 1994, 1995 and 1996 by adjusting and trending forward actual 1993 expenditures for items and services included in the national benefit package. (§6002)

    The legislation specifies in considerable detail the adjustments that are to be made to arrive at a fair representation of per capita spending for alliance-eligible individuals. Whether sufficient data exist to make these adjustments is another question entirely.

2a. By January 1, 1995, the NHB determines a "regional alliance per capita premium target" for 1996. (§6003(a))

    The alliance-specific targets are based on the "national per capita baseline premium target," adjusted to reflect regional differences in health care expenditures, percent of population un- and under-insured, and use of academic health centers.

2b. "Regional alliance per capita premium targets" for subsequent years are established by the NHB by March 1 of the previous year. (§6003(b))

    After 1996, the new target equals the previous year's target times the "regional alliance inflation factor," also set by the NHB under §6001(a).

    The "regional alliance inflation factor" equals a "general health care inflation factor" specified in the legislation (§6001(a)(3)), adjusted to take into account any material changes in the demographic and socio-economic characteristics of a particular alliance's population. (§6001(a)(2))

    The factor may be reduced if the alliance exceeded its target in previous years. (§6001(d)) (See item 10, below.)

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3. By April 1 each year, the regional alliance sends to prospective health plans NHB-specified information "necessary to enable a plan to estimate, based upon an accepted bid, the amounts payable" to the plan (i.e., actual revenue the plan will receive). (§1341(a))

   Alliances must disclose to prospective bidders the "regional alliance inflation factor" (§1341(a)(2)(D)), but may choose whether or not to disclose the actual per capita premium target (§6004(a)(1)(B)).

4. Bids from health plans for 1996 are due to the regional alliance on or before July 1, 1995. For subsequent years, bids are due August 1 of the previous year. In submitting bids, plans must agree to accept any premium reduction that may be imposed under §6011 (see item 7 below). (§6004(a))

5. If the state's plan permits it, alliances negotiate with health plans over premiums to be charged. After negotiations, health plans may submit new, lower bids. (§6004(a)(2))

   Alliances are generally required to "negotiate with any willing State-certified health plan to enter into a contract" (§1321(a)(1)) but are not required to offer a contract if the plan's "proposed premium exceeds 120 percent of the weighted-average premium within the alliance" (§1321(b)).

6. By September 1, the alliance submits health plans' final bids to the NHB, along with information necessary to enable the NHB to estimate probable enrollment in each plan. (§6004(b))

7. The NHB determines a "weighted average accepted bid" (WAAB) for each alliance (§6004(c)), and compares it with the per capita premium target for that alliance.

   If the WAAB exceeds an alliance's target, the NHB notifies the alliance on or before October 1. The NHB also notifies both the alliance and each "noncomplying plan" (i.e., plan whose final bid exceeds the target) of the "plan payment reduction" (i.e., the amount by which payment to the plan will be reduced below the plan's bid). (§6004(d))

   After the first year, whether a plan is "noncomplying" is determined by comparing the plan's bid, not with the alliance's target premium, but with a plan-specific "maximum complying bid," which equals the previous year's premium for that plan, less any plan payment reduction for that year, plus the dollar amount (not percentage) by which this year's alliance per capita premium target exceeds last year's target or WAAB, whichever is less. (§6011(d))

7. (con't)

Details of how the NHB will calculate the actual reduction for each noncomplying plan are specified in §6011(c). The reductions guarantee that the new WAAB for the alliance, after implementation of the reductions, will equal the target (unless actual plan enrollment differs from pre-year estimates). The regional alliances implement the reductions when paying health plans under §1351.

8. Each "noncomplying" health plan passes on the plan payment reduction to its providers, both participating and non-participating. The method for calculating the amount of the reduction is specified in the legislation and by the NHB and cannot be changed by the health plan. Providers must accept the reduction and cannot charge patients more because of it. (§6012)

9. The alliance publishes the final information about premiums for each of its health plans, and other required information, and holds an open enrollment period during which individuals (family heads) choose which plan they wish to enroll in. Enrollment is effective January 1.

10. Once the final enrollment in each health plan is known, the alliance reports this information to the NHB, which calculates the "actual weighted average accepted bid" for the alliance for that year and compares it to the alliance's per capita premium target. (§6001(d))

If the actual WAAB exceeds the alliance's target, the "regional alliance inflation factor" for that alliance for the two succeeding years is reduced to make up the overage. (§6001(d))

Mr. WAXMAN. I will start off the questions. At the risk of stating the obvious, I think it is clear that I am not likely to persuade you that the President's proposed health plan premium caps are a good idea; but if my memory serves me, just a few weeks ago, representatives of the insurance industry appeared before this subcommittee and endorsed universal coverage including a requirement for employers and workers to contribute to the cost of health benefits.

As I see it, the President's plan includes premium caps as a backstop to market forces to assure that we get the savings to help pay for universal coverage.

Without such savings, the President would have no alternative but to turn to a broad-based tax, which he clearly doesn't want to do. Since catching the growth in health plan premiums is critical to paying for universal coverage, which I believe all of you support, how would you propose to pay for universal coverage? What kinds of savings estimates can you provide us for the types of managed competition you favor?

And if it is not enough to pay for everyone, what kind of taxes or revenue measures do you support to pay for that universal coverage?

Mr. NIEMIEC. I wish there was an easy answer to the question that you pose, Mr. Chairman.

Mr. WAXMAN. We sure wish there were, too.

Mr. NIEMIEC. First, let me say that I think, as I was listening to people who were testifying earlier today, there seems to be something taken for granted about the managed care approach toward health care cost containment, that it is not sufficient, that over time it will be proven not adequate to do what needs to be done in terms of bringing the cost of our system under control.

I don't know that I would agree with that. Time may be required in order to have it become truly effective. Support will certainly be required in terms of urging the citizens of the country, employers, physicians, hospitals et cetera, to participate actively and aggressively in the system. Those things are probably true.

The business of being able to extend to all American citizens universal coverage which is, indeed, a goal and objective and principle that we fully support, may be in light of that something that requires more time to achieve than originally designed in the program that we are looking at today. It may simply take more time.

The concept of a backstop is somewhat intriguing. If it is felt seriously that the private sector efforts at cost containment will not prove adequate and, therefore, we need the backstops, that would assume the backstops would be employed, it would seem to me.

If, then, the backstops are employed, we are stepping into a price controlled environment. And premium controls and price controls I consider to be identical.

Mr. WAXMAN. Is it your choice to say we will forgo universal coverage and let those who have health care continue to have it but those who don't, don't?

Mr. NIEMIEC. Absolutely not. But I think we may have to consider moving more gradually toward it.

Mr. WAXMAN. Let me see if the others want to respond.

If you want universal coverage, how do we get it without a tax increase or clear cost containment.

Mr. NIEMIEC. Let me cite some of the experiences we have had in Minnesota. We have been at this for a couple of years in Minnesota with our Minnesota Care bill, and we have much the same objectives that the President has.

We have had some good success—Dr. Thorpe, in his testimony, mentioned the State's health plan for State employees. And since managed care was introduced in 1990, the rate increases have averaged less than 6 percent each year. In fact, this year, they have been 0 percent.

So this has been a good thing. Through voluntary pools, it has brought labor and management together on this. One of the things we are trying to do is get to universal coverage. We understand the same issues and have more problems on the State level with it.

But we see it as a, partly, the ability of putting volunteer pools together; and all of us in health plans in Minnesota have a clear goal that we need to find ways to integrate the uninsured, those on Medicaid into the pools. And we think that we can bring those together.

I think the answer that I would give you, the reason that I think there is evidence in Minnesota that a voluntary approach is working, is that the trends have been down there significantly; and we are making price data available to all purchasers.

Mr. WAXMAN. I have no more time left.

If the other two want to respond briefly.

Mr. HAVENS. Mr. Chairman, I would reinforce a comment I made earlier. I think there needs to be very close attention paid to the results that are coming from managed care in the last 24 months.

I realize there have been plans in the country for over 30 years, but there are major changes that have occurred in the last couple of years. The rate in which physicians are enrolling in these plans, the rate in which purchasers are changing their benefit plans, today health care inflation in some markets is between 0 and 5 percent.

Mr. WAXMAN. How much of that is due to the fact that the beneficiaries are paying more out of pocket?

Mr. HAVENS. For the most part, the benefit plans from HMO's have not changed a bit. They have changed in other settings but not from HMO's.

Mr. WAXMAN. I have to move on. But I appreciate your answers and the limitations.

Mr. McMillan.

Mr. MCMILLAN. I think the key question is whether you think the President's plan is going to encourage competition and if, in fact, the backstop might end up becoming the pitcher very quickly.

My view is that the President's plan will not encourage competition; it will encourage consolidation; and that the only leverage that exists will be the premium cap. And that will happen rather quickly. Which, basically, means the top-down and premium caps become price controls, as someone said, I think, very quickly under this system unless you do the things that get the costs down first, the difference in cost and price, unless you get the costs down first, which I don't think the President's plan does except in the area perhaps of administrative costs. But then it adds administrative costs so it may not do that.

On malpractice reform, I think it has the right words in there, but it doesn't get on with it. It sets it up as a pilot program. There are very good alternative bills out there. I introduced one, H.R. 1989.

We shouldn't be kowtowing to trial lawyers. We should be pitting it into effect. Even the American Bar Association endorses it so do 88 percent of the public.

You all come out—or most of you come out of the insurance industry. Given the fact that you have got caps, given the fact that you have got consolidation of purchasing, given the fact that your industry operates, I think, on about a 1.7 percent profit margin, and that is with your ability to minimize risk, which would be taken away from you under this proposal, aren't you, in effect, going to be pushed to the brink of insolvency rather quickly or even into consolidation, that is going to further place power in the regional alliances and perhaps even merge them?

Won't you, in effect, cease to become part of the competitive process in a fairly short period of time?

Mr. NIEMIEC. I would like to take a shot at that. I think you raise some good points about insolvency and what premium caps would do in conjunction with that.

If I am looking at setting rates for my plan and I have premium caps, in effect, I am going to be very careful about setting lower rates. If I guess wrong as an actuary and set the rates too low, I will have great difficulty with premium caps, of ever bringing the rates up so that I can recapture the reserves I need to be solvent.

So, first, you are going to see the price caps being much more of a ceiling. I will be afraid to be aggressive. And, furthermore, if a few plans get in trouble and become insolvent, you will probably have a situation with guarantee funds where the stronger plans will have to subsidize those.

And you may have a situation where there would be a great deal of consolidation where, even though you have strong plans, they are not going to be able to survive.

So I would share your concern.

I would like to say I am a veteran of 30 some odd years of competitive wars in the insurance business. I have great faith that this will remain a very competitive environment going forward. I am certain there will be some consolidation but there will remain a very competitive environment and the competitors will be different ones than we have traditionally seen, competitors in providing health plan services to the American consumers, hospitals and physicians gathered together with insurance companies, Blue Cross plans, existing HMO's, and they will fight aggressively for market share. So I have great faith that competition will continue to work to keep costs under control.

The President's proposal puts some power on the buyer side which was not there before and that should further serve to enhance the competitive nature of this business going forward.

It is going to be a tough business. Some of us will win and some of us will lose. I represent a very large company but it is entirely possible for us to lose in this process going forward. So we view it as continuing to be a very highly competitive business going forward and that should work to serve the consumer.

Mr. McMILLAN. If an insurance company had to raise capital to expand its capacity to compete for a much larger pool out there in the insurance market, do you think with the profit margins and price controls by the Federal Government and consolidation of purchasing power in State health care alliances you would be able to raise capital to expand your business?

Mr. NIEMIEC. That was essentially my comments in the earlier statement.

Mr. McMILLAN. That is contradictory with the first response to my question.

Mr. NIEMIEC. If there are premium caps in place, we are going to deflect capital. It will be very hard for me to address my board of directors and ask for more money to put in an environment where there is solid price control and premium cap control the way we see it now. A competitive market will not result in that deflection of capital.

A reasonable return on the invested capital would still be there. If it is not, then they will back away. There is a reasonable rate of return currently available that is, as we see it, threatened by global budgeting and price premium cap control.

Mr. McMILLAN. I think there are other plans. I support a plan that would encourage consolidation in purchasing groups without the Federal controls. The President's plan doesn't do that. It is very dependent on Federal controls and price fixing.

Mr. WAXMAN. Thank you, Mr. McMillan. Mr. Wyden.

Mr. WYDEN. Thank you all.

Ms. Green, can the market, in your opinion, produce better value including lower premiums than would the Clinton caps?

Ms. GREEN. I think that the market has already to some extent produced better value. I think that the history that you have seen over the last 5 years of what has been happening despite the fact that we still see the rises in cost is a very clear indication of that. For example, the cost of caring for an AIDS patient, for instance, in the last year's of their life has decreased by more than 25 percent in the last 5 years, and that is definitely and directly as a result of what is going on in managed care plans today.

I think that the private market probably has the ability and the will to respond far more quickly than what is controlled by government.

Mr. WYDEN. I guess what puzzles me, if you believe that the market alone can produce better value, specifically lower premiums than would the Clinton caps, what in the world is wrong with having the Clinton caps as a fallback, as a safety valve? You have already told me that you believe we aren't really going to need it. The market is going to work, the market is going to be way out in front of the Clinton caps. What is wrong with having some version of a cap as a safety valve?

Ms. GREEN. I think that the cap is the opposite of a safety valve. I believe that a cap says that regardless of what happens, new and dread diseases, new technologies that may prove beneficial but are also cost increasing, are the ones that are going to fall victim to a premium cap. As far as I am concerned, the fact that you have capped premiums means that you have no safety valve.

Mr. WYDEN. I find that hard to follow. Let me just tell you, I am prepared to give the market the first crack at it. I come from a town, Portland, where we already have managed competition, so we feel that there is a significant future for it. But it seems to me if you believe in markets, and I come from a place where one works, at some point you have to be willing to say if, when and where markets don't work, something kicks in to ensure that people get the low premiums that you want and I want.

We are going to have a chance I guess to talk about this more over the years, but I would point out that people like me are willing to give the markets first crack. I come from a place where we have seen the future and we think it works, but I think people like you all will have to be willing at some point to say, look, if you give us a chance to take the first crack at it and make a market and have alliances that really allow for choice, when, if and where they don't work, people like me are going to say we are going to have to try something else.

The GAO has given this committee a number of reports over the years on dread disease policies and the policies being of poor value, they inflate costs and don't give people their money's worth.

Would you at the HIAA be willing to work with us, and I know that many in the Clinton administration have an interest in this issue as well, to establish some Federal standards at least for these dread disease policies so that in the new health care landscape people don't end up buying so much junk in the dread disease area?

Ms. GREEN. The specific policies that you mention in that area of expertise is not my own. I think that is a very good question. I would be more than happy to take that back to my association, but unfortunately now I can't answer it.

Mr. WYDEN. Fair enough.

Each of you mentioned in your testimony the need to attract capital into the managed care industry, capital for expansion of facilities, for new data systems, infrastructure for managed competition. You also stated that the President's premium caps would likely drive capital out of the industry.

Earlier today we had testimony from Dr. Thorpe that the President's plan has built in an allowance to such capital needs in the form of a 15 percent administrative allowance within these caps. What do you think of this provision, Mr. Havens, and if you all think that a different approach is necessary maybe it would be helpful to have your own estimate of what it would take to build this kind of concept into the premium structure of health plans?

Mr. HAVENS. Congressman, I am not sure that I am familiar enough with that provision that Mr. Thorpe described. I have a little difficulty combining administrative allowance with access to capital. I am going to have to look more carefully at that.

I wanted to add to your earlier question just a thought. One of the issues I think is terribly important in innovation and change in the health care delivery side is the creation of new types of health plans. Let's for a moment put aside the existing ones and there are many and they will have capital needs, but I think it is important to keep in mind the next two generations of health care plans and there unfortunately, correctly or incorrectly, the sources of capital are very nervous about premium caps. I think it would

be helpful to have Wall Street here to talk about their concerns about this. I am concerned that just having the premium caps in there will make it extremely difficult for new plans to be created and compete in a competitive market. I will look more carefully at the proposal and will get back to you.

Mr. WYDEN. Mr. Chairman, maybe we can ask the witnesses to respond to this one in writing. That would save time.

Mr. WAXMAN. That would be helpful.

Mr. McMillan.

Mr. MCMILLAN. I think what we are creating here is analogous to the airline industry. If we follow this pattern, we are going to head down a road of enormous consolidation and there will be three or four unprofitable players or marginally profitable players so the government will become an underwriter of last resort.

I think there is a better way to go at this that deals with the question the chairman raised of universality and maximizing the comparative response, and that is the government defining its role in terms of its support to the individual. The financial subsidy flows to the individual who then, as long as they buy an acceptable standard level of care, can use the certificate to buy into whatever plan they choose. I think that you can do that up to a financial cost of or an actuarial cost that is fully adequate. It doesn't set a cap but it says this is what the government is prepared to pay.

And then the competitive marketplace has to deal with that whether it is in managed care or fee-for-service. I don't see anything wrong with that when you cost it out on an actuarial basis. It can essentially be done within the scope of what Federal and State expenditures are today.

My staff actuarially costed it out up to 300 percent of poverty at which you would get a 30 percent family benefit subsidy and include in it managed care with a big pharmaceutical provision.

My question would be, do you think a certificate system assuming we work through all the numbers would tend to maximize competition and fulfill the promise of universal coverage if it is properly structured? Anyone?

Mr. NIEMIEC. I will try to answer that, Representative McMillan. I am not sure that I understand your proposal as such. If I do understand it, it is using certificates or vouchers for persons who would otherwise be eligible to receive government assistance to purchase health care plans and then have the individual so benefitted approach the insurance markets and acquire their coverage as independent consumers.

Mr. MCMILLAN. They could do that. Chances are they would not do it that way. They would do it through groups because you would have group reform that gave them universal access to group coverage.

Mr. NIEMIEC. But they would interface with the plans as individual or small groups of consumers. It would give one added benefit; it would go toward the point of making people cost conscious in their decisions about their health plans.

Mr. MCMILLAN. I would have a 20 percent co-pay as a feature of it.

Mr. NIEMIEC. Which is an essential part of the long-term needs. I think the fundamental engine of reform would not necessarily be——

Mr. MCMILLAN. This would be designed as a complementary to dealing with other reforms which the President does not deal with, like malpractice reform and a host of other things you get as cost drivers.

Mr. NIEMIEC. Those things we would propose be addressed as well and we agree with that fully. But I think that the real lasting driver is the restructuring of the health care delivery system itself in terms of the interaction between plans and third party payers and the providers of health care services. It is that nexus that needs to be adjusted I think in order for us to see long-term, lasting reform providing quality care that we can afford as a Nation through generations.

Mr. MCMILLAN. You don't think that you, as a major underwriter of health insurance, if you had 25 percent of the U.S. market could yourself perform that function of—that, say, might be performed by a regional alliance or by a major corporate alliance to effect the cost reductions and maintenance of quality that are necessary?

Mr. NIEMIEC. If I were trying to imagine a world in which my company had 25 percent of the market, I would expect to turn around very promptly and find government at my shoulder questioning my behavior in the strongest possible terms.

Mr. MCMILLAN. I think you just defined what is going to happen.

Mr. NIEMIEC. Perhaps, but I hope not. I don't think it is going to devolve down to four or five companies. A further comment and a question raised by Congressman Wyden, the business of whether there is a backup and a target, and if it is not accountable, what happens if it doesn't work. Those of us who believe it will work are prepared to be accountable in those terms and are prepared to set targets saying we will provide the data necessary over a course of time to make an analysis of why something does or does not work and what actions perhaps ought to be taken in the future to resolve the cost shortfalls that might occur. We would feel much more confident about a program addressing that on the basis of sound data.

Currently, the data we would have to use to develop at the National Health Board level global budget set by each alliance is simply inadequate and systems to drive the data are not in place. We would see some sense in looking forward and building a solid database to be able to analyze what happens in our health care system prospectively and then take knowledgeable action if some needed to be taken.

Mr. WAXMAN. I want to thank all of you for your testimony today. It has been very helpful and we look forward to working with you further.

Members may have additional questions, and we would like you to respond in writing for the record. Thank you very much.

Our last panel today consists of representatives of hospitals and doctors.

John G. King is the President and Chief Executive Officer of Legacy Health Systems in Portland, Oreg., appearing on behalf of the American Hospital Association; William Dowling is Vice President for Planning and Development of the Sisters of Providence Cor-

poration, Seattle, Wash., appearing on behalf of the Catholic Health Association; Dr. William Coleman is a family physician from Scottsboro, Ala., and is President of the American Academy of Family Physicians; Dr. Jerald R. Schenken is a pathologist in Omaha, Nebr., and is a member of the Board of Trustees of the American Medical Association.

We are pleased to welcome you to our hearing today. Your prepared statements, without objection, will be in the record in full. We would like to ask you to limit the oral presentation to no more than 5 minutes.

Mr. King, let's start with you.

STATEMENTS OF JOHN G. KING, PRESIDENT, LEGACY HEALTH SYSTEMS, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; WILLIAM L. DOWLING, VICE PRESIDENT, SISTERS OF PROVIDENCE HEALTH SYSTEM, ON BEHALF OF THE CATHOLIC HEALTH ASSOCIATION; WILLIAM H. COLEMAN, PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS; AND JERALD R. SCHENKEN, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Mr. KING. Thank you, Mr. Chairman, and members of the subcommittee. I am John King, President of Legacy Health Systems in Portland Oreg. I am here representing the American Hospital Association and its membership.

I would like to focus my remarks on cost containment in health care reform and highlight the success that we have had in Portland that the Congressman referred to in Legacy Health Systems. We in hospitals are for real reform and we will evaluate the proposals on the basis of universal access, integrated health care delivery, economic discipline, balancing benefits for adequate financing and public accountability as well as antitrust and medical liability reform. AHA recognizes that accelerating costs are unacceptable and acknowledges that the Nation has a right to expect care to be delivered in a more efficient fashion than it has been in the past.

Let me turn to the story of Legacy Health System in Portland, Oreg. This is a five-hospital system with a network of physicians, immediate care clinics, and insurance plans. Containing cost of medical care, we think, requires innovation and cooperation and forging new partnerships and we think we are succeeding.

In fiscal year 1991 through 1993, our cost per adjusted hospital admission rose only 4 percent, and for fiscal year 1993 rose only 0.6 of 1 percent. Achieving this was the merging of three of these five hospitals in downtown Portland into one administrative and medical organization, that we created one management team where there were three, one medical staff where there were three, and merged clinical services within these organizations.

It is important to note that Portland is a mature managed care environment with HMO's and PPO's. The Portland area providers have learned to provide care on a fixed per capita budget and learned to restructure the way care is delivered.

As this committee considers how best to contain costs, it seems to us that you have two fundamental approaches. The first involves an arbitrary limit on health care spending based on a predetermined rate of growth for health care or the need to generate budget

savings. The second involves economic discipline achieved by reforming the way health care services are paid for and provided while simultaneously establishing a process, not a formula, under which an independent national commission evaluates the level of payments in light of the benefits to be provided.

This latter approach is the one that AHA favors and we think will achieve cost containment by giving health care plans and community care networks and other groups the ability to provide cost on a person-to-person basis, to eliminate extensive duplication of services and technology and establish a seamless system of care. Health plans would then be working under incentives to manage care.

Let me use the Portland area as a case in point. Nearly 41 percent of the under 65 in Portland is enrolled in a HMO, another 45 percent is enrolled in PPO's. For those over 65, 56 percent are enrolled in a Medicare HMO. That is very unusual. We think this managed care phenomena results in significantly lower hospital utilization, which reduces costs.

For example, on a per thousand basis, inpatient hospitals are used at the rate of 435 days per year per thousand in Portland compared to a national average of 890, less than half. The average length of stay is 4.7 days, the national average is 7.3. We are convinced that with properly constructed economic incentives to the pay providers, a fixed amount of money to serve a defined population can work as a cost containment methodology.

AHA has serious concerns about those reform plans now before Congress that would achieve cost containment with a formula-driven approach.

The President's bill has strong limits on spending, a limit on the amount employers and employees can spend.

There is a limit on the Federal Government's subsidy for low-income people and small business. There are extraordinary reductions projected for Medicaid and Medicare in the short-term.

Others, like the proposal by the Senate Republican Task Force on Health and the bipartisan Managed Competition Act of 1993, have also been advocating reductions in Medicare and Medicaid.

On the private side, the Clinton proposal caps spending. To sum up, we hope you will consider the right incentives at the local level as well as the caps at the Federal level.

Mr. WAXMAN. Thank you very much Mr. King.

[Testimony resumes on p. 291.]

[The prepared statement of Mr. King follows:]

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**Statement
of the
American Hospital Association
before the
Subcommittee on Health and the Environment
of the
Energy and Commerce Committee
United States House of Representatives
on
Cost Containment in Health Care Reform**

November 8, 1993

I am John G. King, President and Chief Executive Officer of Legacy Health System, Portland, Oregon. Legacy is a health system serving the Portland metropolitan area with four hospitals, a home health program, and a network of physicians and immediate and primary care clinics. I am here today, as a former member of American Hospital Association Board of Trustees, representing the American Hospital Association and its 5,000 member hospitals and health care organizations nationwide.

Members of this subcommittee and the full committee have worked for many years in the effort to extend and improve health care coverage for the nation. I know you share the American Hospital Association's excitement about the real opportunity before us for achieving that goal.

Blueprint for Real Health Care Reform

For more than two years, America's hospitals have worked to shape our own blueprint for health care reform. As we see it, real reform must achieve at least six objectives, and we will evaluate every proposal based on its success in meeting them. They include:

- universal access in a reasonable time period financed in a pluralistic manner;
- redeveloping health care delivery into an integrated and coordinated system able to address the needs of the population;
- economic discipline based on clear incentives -- such as paying providers a fixed amount of money to serve a defined population -- rather than micromanagement;
- balancing promised benefits with adequate financing;
- public accountability for the clinical effectiveness and economic efficiency of health plans; and
- antitrust and medical liability reform.

In our view, these goals are interrelated. Achieving one at the expense of another could place reform at risk. For example, expanding access without 1) controlling the cost of care, and 2), providing for adequate financing, would make the new benefits vulnerable to attack for accelerating the growth of health care spending. AHA's third goal -- economic discipline -- recognizes that accelerating costs are unacceptable, and acknowledges that the nation has a right to expect care to be delivered more efficiently than in the past.

Society's Charge -- Containing Health Care Costs

Setting cost containment goals in a vacuum -- without considering what it costs to provide care and streamline operations -- could have equally serious consequences for reform, undermining both access to care and reform of the delivery system. If health plans are underfunded, a health security card will do little to ensure that enrollees receive the guaranteed national benefit package, nor will it afford much security. We need an appropriate level of resources to achieve fundamental reform. For example, reconfiguring hospitals and other provider services into more efficient cooperative arrangements takes both human and financial resources. We know from experience that laying out a solid plan for merging services between two hospitals, or between a hospital and physician group, can take a year or more. The infrastructure investments we all endorse in order to reduce administrative costs -- electronic billing, computerized patient

records, new information systems -- also require appropriate resources before they can be put into place.

Hospitals must have the resources to allow them to do this -- resources that could be freed up through the greater efficiencies and lower administrative costs that are possible with real reform. Managers in the system must have the tools and flexibility to manage. They cannot reallocate all resources at once. The payoff in terms of cost containment for the emphasis on primary and preventive care comes long after the initial investment of resources to provide such services. For example, greater use of medically appropriate mammography would, over time, improve detection of breast cancer at an earlier stage, when it can be more successfully treated, and at a lower cost as well. But in the short term, there would be an <u>increase</u> in costs, as we pay for a greater number of screening mammograms. If the financial environment is too constrained at the outset, however, reform of the delivery system -- including shifting our emphasis to early detection of disease -- may never get off the ground.

Legacy Health System's Story

Let me turn the subcommittee's attention to the story of Legacy Health System. At the outset, I said that Legacy Health System was a four-hospital system with a network of physicians and immediate and primary care clinics. It is Legacy's mission to

enhance the quality of life and improve the health status of the community we serve. To accomplish these goals, we are developing an integrated health care system designed to provide high quality cost effective care by managing the care of the patients we serve. Containing the cost of medical care requires innovation, cooperation, and forging new partnerships. And we are succeeding at Legacy. From fiscal year 1991 through fiscal Year 1993, our cost per adjusted hospital admission rose only 4 percent. *And for fiscal year 1993 our cost per admission rose only six-tenths of one per cent.* Our financial plan released in April, 1993, listed no price increases for hospital services. We expect our financial plan for spring of 1994 will also have *no* price increases. At Legacy, our cost containment effort is driven by four strategies: managed care, continuous quality improvement (called CQI Legacy), administrative consolidation, and integration of clinical services.

Managed Care

For Legacy, managed care is more than Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). For Legacy, managed care is the management of medical treatment and health care based on delivering medically appropriate care that works in a cost-effective manner. The various health plans that Legacy serves save our patients between 5 and 30 percent of their historical health care costs. Our success in managing care requires that the physicians, nurses, laboratory clinicians and

hospital administrators work in partnership to contain cost while providing quality care.

CQI Legacy

Legacy's Continuous Quality Improvement Program (CQI Legacy) is one of our principal levers in balancing quality and cost. CQI Legacy ensures that the people who do the work have the power to make positive changes. Because they know the most about their jobs, they are best able to identify and remove problems and improve productivity, make decisions and improve the quality of care. Our efforts to maintain and improve the quality of the care we deliver rely on research into the clinical outcomes of procedures. To monitor and coordinate future outcomes research throughout Legacy, we created a council for outcomes research.

Administrative Consolidation

Our first steps toward consolidation began with merging the three downtown Portland hospitals -- Emanuel, Good Samaritan, and Holladay Park. We merged administratively into one hospital operating on three sites. We then merged the medical staffs of the three hospitals into a single medical staff. And we went on to merge other functions, such as purchasing and material services, Legacy Health Plans management, and planning and resource allocation.

We were then faced with the hard fact that the Portland area has far more hospital capacity than needed to serve both its current and projected populations. This fact, added to the nationwide shift from inpatient surgery to outpatient procedures, led us to announce the closing of one of our three hospitals, Holladay Park Medical Center. Our previous integration of its services into the larger whole meant that Holladay Park's closure could be handled with minimal disruption to patients. Legacy now leads the region in reducing duplication of services and integration of health care delivery.

Integration of Clinical Services

In addition to the consolidation of the medical staffs of Portland's downtown hospitals, we are integrating the clinical services of other hospitals and providers. Legacy's partnership with primary care and specialty physicians in the Portland area assures that our community has access to primary, secondary, and tertiary health services. Mount Hood Medical Center and Meridian Park Hospital offer primary and secondary services to the growing populations east and south of Portland. A network of physicians' office buildings, immediate care clinics, occupational medical clinics and residency-based primary care clinics weave the system together.

Partnership with employers is also key to the success of Legacy. We have forged an agreement with Portland's Precision Castparts Corporation that will use highly innovative approaches to contain the cost of health care while improving the health status of the company's employees. For example, we're conducting a health status survey of all employees, and then monitoring the improvement we expect to see after intensive preventive and wellness programs are implemented.

It is important to note that the Portland area is a mature managed care environment with a high penetration of Health Maintenance Organizations and Preferred Provider Organizations. Providers serving the Portland area have learned to provide health care within a fixed budget system through some form of capitation in a highly competitive market. This is a direct example of marketplace incentives at work. By integrating health care delivery and restructuring internal operations, we have been able to maintain high quality care while containing cost to the patient and the system.

Cost Containment Strategies

As it considers how best to contain costs, this subcommittee will be forced to choose between two fundamentally different approaches. The first involves writing some sort of arbitrary limit (or limits) on health care spending into the law, based on some notion of the appropriate rate of growth for this sector of

the economy or on the need to generate sufficient savings to offset any new Federal budget costs generated by reform. A limit of this sort could be imposed on insurance premiums or on payments for health care services, but both approaches would be driven by a formula based on factors having little to do with the actual delivery of care. Their rigid application may seriously penalize those providers who have made conscious and appropriate efforts to reduce costs.

The second approach involves achieving some economic discipline immediately by reforming the way health services are paid for and provided, while simultaneously establishing a process -- not a formula -- under which an independent national commission evaluates the level of payments in light of the benefits to be provided.

This latter approach, which AHA favors, would achieve cost containment by giving providers the economic incentive to work together in health plans or community care networks℠ -- cooperating groups of local providers paid on a capitated, or per-person, basis -- to eliminate expensive duplication of services and technology and establish a seamless system of care that works better for patients. In our view, health plans would then be working under incentives to manage care, rather than managing providers and patients.

Let me use the Portland area as a case in point. Nearly 41% of the Portland area population under age 65 is enrolled in HMOs. Another 44% is enrolled in PPOs. Of those over age 65, close to 56% are enrolled in an HMO Medicare plan. This managed care phenomenon results in significantly lower hospital utilization, which of course reduces health costs. Portland's inpatient days per 1,000 persons is 435, compared to the U.S. average of 890 days per 1,000. Average length of the hospital stay is 4.7 days, versus 7.3 days for the nation as a whole. We are convinced that properly constructed economic incentives that pay providers a fixed amount of money to serve a defined population work as a cost containment methodology.

And we're just as convinced that what doesn't work is the kind of government micromanagement or price controls that are likely to be the enforcement mechanism if we try to achieve cost containment through arbitrary federal limits on health care spending. As all price controls imposed in the last 25 years have shown, incentives for innovative programs and improved care would be sidetracked and replaced by strategies to survive and outsmart the regulators. Rate setting in health care would create underfunding, promote unbundling of services and therefore expand utilization, and would subject the well-being of patients to the political process.

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A better approach is to establish a process for evaluating health care spending in light of benefits. This avoids the risk inherent in guessing -- far in advance -- what the appropriate level of health care spending should be for a particular year.

And it would enable policymakers to achieve a better balance between promised benefits and adequate funding by basing their decisions on better, more recent information on demographic changes, scientific and technological advances, developments in productivity and quality of care, and other relevant factors.

Cost Containment Strategies in Current Proposals

AHA has serious concerns about those health care reform plans now before Congress that would achieve cost containment with a formula-driven approach. Although some believe the President may have backed away from the explicit Medicare and Medicaid caps proposed in the September 7 draft version of his plan, there are nevertheless strong limits on spending in the President's bill. There is a limit on the amount employers can spend; there is a limit on the amount employees can spend; there is a limit on the federal government subsidy for low-income people and for small business. And, there are extraordinary reductions in Medicare and Medicaid payments to hospitals. The reform proposal of the Senate Republican Task Force on Health also suggests reductions in spending for both the Medicare and Medicaid programs. Sponsors of the bi-partisan Managed Competition Act of 1993,

introduced by Rep. Jim Cooper (D-TN) and Rep. Fred Grandy (R-IA), have also been active in advocating reductions in Medicare and Medicaid payments.

While the goal of these proposed Medicare reductions is to squeeze out waste, none of these plans propose applying to Medicare the same economic incentives that would promote efficiency in the rest of the health care system. Instead, these spending reductions are to be carried out through a series of arbitrary and technical changes. These changes are not intended to fix what's wrong with the Medicare program. Instead, their purpose is to fund the new federal costs associated with reform. While there may be merit to the new benefits funded by these cuts, we can't support underpaying hospitals in order to finance them.

A similar disconnect of actual needs from resources happens on the private side of the Clinton proposal, where spending growth is capped by tying it to the Consumer Price Index (CPI). But the CPI has no real link to the actual costs of providing health care; health care has its own set of input costs that aren't reflected in the CPI -- labor costs that are driven up by health personnel shortages and the steeply rising cost of new medical technology, for example. This is a particular problem in the early years of reform when the health care delivery system would have to adapt to massive changes.

Another example of the shortcomings of rigid spending limits is the proposed cap on Federal subsidies to low-income individuals and small, low-wage businesses under the Clinton plan. In an effort to provide fiscal certainty to the Federal government, the plan would strip away any sense of security these groups might have by requiring that the subsidies they were depending on be scaled back if demand proved greater than anticipated. This would apparently occur regardless of whether the pressure on subsidy funding was caused by a failure to control health premiums adequately, or by more individuals qualifying for a subsidy because of changing economic conditions, such as would happen with a higher unemployment rate.

We agree on the need to slow health spending growth. But who among us sitting here today could say with any certainty what health spending should be five or six years from now? To try to control spending through a rigid formula amounts to putting the system on cruise control, taking one's hands off the steering wheel, and hoping for the best. That is not a responsible way to navigate in the uncharted territory of health care reform. Why? Because it doesn't allow us to adjust course to accommodate unforeseen circumstances. The slowness of the economy in coming out of the recession, unanticipated crises such as the AIDS epidemic -- all caution that we keep our hands firmly on the steering wheel. And the way to do that is to match health needs with available resources in an on-going, open and public way.

In our view, that should be the job of an independent national commission.

Conclusion

To sum up, hospitals recognize that moderating growth in health care costs is a legitimate national need. Our long experience in health care delivery tells us, however, that significant cost containment will not be achieved by half-measures. Significant savings can only be achieved by bold strokes -- by realigning today's perverse financial incentives that send hospitals in one direction; physicians in another.

We believe that capitated payment to a community care network[sm] -- a per person fee paid to a cooperating group of health care providers -- does the best job of realigning those incentives. Our track record at Legacy Health System shows that provider integration and cooperation <u>can</u> result in significant savings.

We also understand your need to have a reasonable idea of the federal government's financial exposure when we restructure the one-seventh of the economy that is our health care system. We urge you to reject the simplistic notion of setting an arbitrary limit on health care spending. Such a limit does not allow for mid-course corrections when unexpected circumstances arise, and it does not preserve the very necessary link between spending and people's actual health needs.

Instead we strongly believe that putting in place the right incentives and allowing savings to flow from the grassroots up -- and Legacy Health System's cost containment record shows that this approach works -- allows us to achieve a very important goal: making sure that promised benefits have adequate financing. Without that balance, our shared vision of giving every American health security could become only a hollow promise.

Mr. WAXMAN. Mr. Dowling.

STATEMENT OF WILLIAM L. DOWLING

Mr. DOWLING. Thank you, Chairman Waxman. I am William Dowling, Vice President for Planning and Policy Development at the Sisters of Providence Health System in Seattle, Wash. We think there are changes that are needed in the Clinton bill.

This afternoon, I want to make just three points: First, true cost containment can occur only through reform of health care delivery.

When CHA developed its own proposal for health care reform 2 years ago, we started with delivery reform as the way to make health care better coordinated, less costly, and more responsive to peoples needs.

The centerpiece of the CHA plan is the integrated delivery networks, a community-based organization of providers able to assume financial risk for a full continuum of health care services.

It receives a risk adjusted capitation payment and is held accountable for the health status of the enrolled population.

CHA believes the kinds of delivery reform embodied in integrated networks is essential for true long-term cost control. This is because the incentives encourage better primary care services in less costly settings, more appropriate capacity levels, and more rational use of high-tech services.

Limits on expenditures without delivery reform are doomed because they would not address the underlying problems.

They would only build on today's fragmented and problem-ridden system. Our Nation must find a way to turn down the heat rather than force the lid on a pot of boiling water.

My second point: Reform must include a flat budget. CHA's health care reform budget includes a national, global budget; and we support the President calling for a national expenditure backstop.

This is an unusual position for a provider organization to take, I realize. But we thought it through very carefully, as outlined in detail in my written testimony, and concluded that there is just no guarantee that managed competition alone will slow health spending adequately.

It, and other purely market-based approaches, certainly holds promises; and we are convinced, as I indicated earlier, that effective delivery reform will dramatically curtail spending in this Nation. But there are too many uncertainties about managed competition to completely give up the certainty of a backstop.

Managed competition has never been tried on a nationwide scale, and we do not know that people will make the decisions that the theory of managed competition says they will. The consequences of being wrong are simply too severe.

My final point: The President's legislation needs to be strengthened by employing a more informed, open, and publicly accountable process for establishing a national budget.

CHA's proposal calls for a bottom-up, top-down, national budget setting process that would incorporate critical information on population needs and differences from State to State, changes in technology, local system efficiencies, et cetera.

Our plan, likewise, outlines checks and balances that would help ensure explicit accountability to the providers for each year's global budget.

In sharp contrast, the President's plan calls for a top down only approach to the national budget defined by a formula driven rate of increase.

In CHA's view, this approach misses an opportunity to make health care expenditures more reasonable but consistent with changing health needs, the public's own view of the appropriateness of tradeoffs between health care and other important social goals, et cetera.

We urge you to retain the concept of a national budget backstop but to resist the temptation to use a simplistic formula for determining the annual allowable increases in national health care expenditures.

Equally important, and in conclusion, national health care legislation must lead to the reform of the delivery system as well as reform of financing.

CHA stands ready to achieve these ends. I appreciate the opportunity to speak on their behalf.

Mr. WAXMAN. Thank you very much Mr. Dowling.

[Testimony resumes on p. 308.]

[The prepared statement of Mr. Dowling follows:]

STATEMENT OF WILLIAM L. DOWLING

Good afternoon, Mr. Chairman and members of the Health and Environment subcommittee. I am honored to appear before you today to discuss how to ensure cost control in a reformed healthcare system.

My name is William L. Dowling. I am Vice President for Planning and Policy Development at the Sisters of Providence Health System in Seattle, Washington. The Sisters of Providence serve the healthcare needs of people through 22 institutions and facilities and through sponsored managed care plans. The System operates 3,462 licensed acute care beds and 1,015 long term care beds with 16,382 full time equivalent employees in the states of Alaska, Washington, Oregon and California. Subscribers of managed care plans totalled 420,684 in 1992.

I am here today in my capacity as a member of the Catholic Health Association's (CHA) Leadership Task Force on National Health Policy Reform. CHA represents more than 1,200 healthcare facilities and organizations that make up the largest group of not-for-profit healthcare institutions under a single sponsor.

Mr. Chairman, CHA testified before your subcommittee last month on our overall evaluation of President Clinton's healthcare reform proposal. At that time, we praised the President for his leadership on healthcare reform; identified eight components of the Clinton plan with which we are in basic agreement; and recommended five ways to strengthen the proposal. It is our view that the President's bill is headed in essentially the right direction.

One key component of the Clinton bill which CHA believes needs to be improved is the focus of today's hearing -- cost containment. This afternoon I will

discuss our views on this subject by first describing CHA's position in support of cost containment in healthcare reform, and then by enumerating our recommendations for strengthening the cost containment provisions in the President's reform legislation.

I. CHA's POSITION IN SUPPORT OF COST CONTAINMENT

The Catholic Health Association developed its own proposal for systemic healthcare reform two years ago. This proposal is anchored in six core values, one of which is the following: responsible **stewardship** requires that our healthcare system must be reorganized so that it can better manage healthcare resources and better control the growth in healthcare spending.

In the process of developing and refining the CHA reform proposal, we systematically examined various approaches that could be taken to slow the rate of growth in healthcare expenditures. We drew six major conclusions from that work:

1) reliable and fair cost containment has become a moral and practical necessity;

2) true cost containment can occur only through healthcare delivery reform;

3) cost control is dependent on universal coverage;

4) reform must include a national budget "backstop;"

5) overall expenditure control is best achieved by linking a national budget to capitated payments; and

6) cost control will be undermined unless healthcare financing for lower income populations is linked to financing for the middle class.

I would like to spend a few moments on each of these conclusions.

1. <u>Reliable and fair cost containment is essential</u>.

As a nation we can no longer allow unpredictable and uncontrolled health spending increases to arbitrarily squeeze out other important social needs, like education and the environment; to enlarge the Federal deficit and weaken the economic competitiveness of many U.S. companies; and to burden families with unmanageable healthcare costs and lost wages.

It is generally recognized that the rate of increase in healthcare spending is unsustainable. The key question is not whether health spending will abate -- annual surges at two to three times the rate of inflation cannot continue indefinitely. The key question is whether we will slow the rate of growth through systemic, orderly reform or let it happen through haphazard, *ad hoc* market forces that result in constricted access and uneven results for employers, patients, and communities. Our concern is that market forces in an unreformed healthcare system will only exacerbate the risk segmentation, cost shifting, and deteriorating insurance coverage that have prompted the call for reform in the first place.

Let me offer an example of what I mean by this. There have been a number of recent press reports about the success of some large employers in reducing their premium increases through selective contracting and other "managed care" techniques. This is certainly encouraging news as far as it goes. But is healthcare really being provided more efficiently, or are costs simply being shifted to small employers and individuals in the community who lack the same purchasing clout as the large employers? To the extent it is the latter, many employers will find insurance

even less affordable, and the insurance companies that serve them will escalate their efforts to avoid risky populations and decrease coverage.

CHA believes market forces can be harnessed to help bring costs under control, but only in the context of fundamental, even-handed reform.

2. True cost containment can occur only through healthcare delivery reform.

The current healthcare delivery system is characterized by costly fragmentation and duplication. Skewed financial incentives encourage inefficient behaviors by both providers and consumers. Specifically:

- acute care and rescue medicine are emphasized at the expense of ongoing primary and preventive care;
- reimbursement policies encourage the use of institutional care in cases where home care is often more effective and less costly;
- episodic emergency room care is too often a substitute for an ongoing relationship with a physician;
- consumers are given few incentives for healthy life-styles;
- the system allows for the inefficient duplication of high technology equipment and services, as well as provider overcapacity; and
- providers often function in isolation from one another with little integration among primary, acute, and long-term care settings. Patients-- especially the elderly and persons with chronic conditions-- often find themselves shuffled among a bewildering array of providers, each maintaining separate medical records and each generating a new and confusing set of healthcare bills.

CHA has concluded that healthcare reform must address these problems in the delivery system if there is to be any hope of containing costs while enhancing clinical effectiveness for patients. Limits on expenditures without delivery reform are doomed

to fail. They would only build on the fragmentation, duplication, and uneven access of the current system. As a nation, we must find a way to "turn down the heat" rather than just force a lid on the pot of boiling water.

CHA's approach to delivery system reform is embodied in a person-centered, community-based Integrated Delivery Network (IDN). An IDN is a set of providers organized to assume financial risk for a coordinated continuum of healthcare services. Providers are linked together through a series of contractual or ownership arrangements. These networks receive a risk-adjusted, capitated payment and are held accountable for improving and maintaining the health status of their enrolled populations. In the CHA vision, consumers participate in network decision-making and choose among competing networks based on quality and service.

The IDN is designed to improve the coordination and efficiency of care by creating new relationships among providers. This occurs **not** through an arbitrary, burdensome, and external regulatory structure, but rather through a re-alignment of financial incentives. Operating under a capitated payment, the IDN must emphasize primary and preventive care, less unnecessary care, better coordinated care, services in less costly settings, more appropriate capacity levels, and a more rational use of high technology services. And because consumers can choose from among competing IDNs, the networks must ensure they are providing responsive, clinically effective services.

3. <u>Cost control is dependent on universal coverage</u>.

The reason for this conclusion is the inextricable relationship between universal coverage and health system efficiency. Anything less than universal coverage creates a vicious circle whereby the uninsured are more likely to receive care in costly settings like the emergency room, and for conditions that have grown more severe with time. The resulting high cost of this care is then shifted to employers who in turn find insurance coverage for their workers increasingly unaffordable. We must break this vicious circle if there is to be any hope of controlling healthcare costs in this nation.

4. <u>Reform must include a national budget "backstop</u>."

An explicit national spending amount is needed for two reasons. First, we have no guarantee that managed competition alone will restrain costs. While it and other purely market-based approaches to reform certainly may contain costs, *the consequences of failure will simply be too severe:* i.e., employers who could no longer afford double digit inflation in their healthcare costs; individuals and families who would be burdened with high out-of-pocket costs and loss of benefits; and continuing upward pressure on the Federal budget deficit.

Second, a national budget is necessary because of the dynamic in the healthcare market known as "moral hazard." This situation is created by the insurance function (private or public) which allows beneficiaries and the practitioners that serve them to consume healthcare resources without regard to cost. The problem is mitigated to the extent that insurance coverage includes cost sharing, as

does the CHA proposal, but over 70 percent of all healthcare expenditures in today's system are by persons who have exceeded all cost sharing requirements. Thus persons with the largest expense to the system are receiving care for which they are no longer personally "paying."

Under these circumstances, ill persons and their families quite naturally demand all potentially beneficial services, and their physicians have no financial reason to constrain the use of resources. This dynamic, combined with the increasing availability and expense of new technologies, will likely place upward pressures on national health spending even in the context of a reformed delivery system.

CHA concluded that the only way to address this problem with certainty is to constrain demand through a broader political consensus in the form of a national budget. As a nation, we may decide to provide all potentially beneficial services to all persons, but effective stewardship demands that we should do so only in the context of an explicit budget aligned with other social needs. This cannot now be accomplished.

The CHA proposal determines a national annual budget through a "bottom up/top down" process. An independent, politically insulated National Health Board recommends an annual rate of increase in national healthcare spending based on uniform data on the relative efficiency of IDNs, changes in healthcare needs, local system capacities, and expectations about new technologies and procedures. Congress approves the budget amount based on an "up or down" vote. If the budget is rejected, the National Health Board reduces the scope of the uniform benefit

package and resubmits a budget recommendation accordingly.

This approach is designed to involve the American people in a very direct and explicit set of choices, and to make everyone aware of the tradeoffs involved in healthcare spending decisions. If Congress funds less than the recommended amount, it does so in the form of a visible negative vote that affects all persons. This may be the "right" decision, but it can only be made with consent of the people who receive the healthcare. On the other hand, the American public may argue to their representatives that the "right" decision is to raise the revenues needed to keep the benefit package intact. In either case the process is explicit and entails neither an arbitrary formula (one-size-fits-all) approach to cost control nor the current unpredictable and uncontrollable nature of public and private spending.

5. Overall expenditure control is best achieved by linking a national budget to capitated payments in a reformed delivery system.

Capitation payment to IDNs is the best way to achieve true cost control under a national healthcare budget. Capitation realigns financial incentives toward "seamless care" and greater efficiency. It allows providers to participate with society in controlling healthcare costs and does so by relying primarily on incentives rather than regulation. Capitation also allows for provider accountability to people and communities based on improved health status.

Rate setting, by contrast, does none of these. Unlike capitation, rate setting freezes into place the fragmentation and duplication in the current system. Rate setting forfeits the opportunity to produce efficiencies across providers through better

patient management and alternative treatment settings. Rate setting also diverts attention away from improved health status and responsiveness to community need. Finally, rate setting requires external volume controls and the continuous recalibration of provider payments required when incentives for "doing more" remain strong.

6. <u>Cost control will be undermined unless healthcare financing for lower income populations is linked to financing for the middle class</u>.

We mean two things by this statement. First, per capita funding on behalf of low wage workers and poor populations for the uniform benefit package must not be allowed to deteriorate compared to per capita funding for higher income populations. CHA believes this would be best accomplished by pooling all funding in a single trust fund before it is allocated to Regional Alliances on a per capita basis. There are, however, other means of accomplishing the same result.

Second, the uniform benefit package must be comprehensive enough that most people find it acceptable and do not feel compelled to purchase supplemental insurance. There will always, of course, be a group of well-to-do persons who will "buy above" the uniform benefit package. But if this group becomes too large it is our view that the uniform package is, by definition, inadequate.

As with many of our positions, there are both moral and pragmatic reasons for keeping all persons under the same financing umbrella, regardless of income. Morally, we should avoid crafting a "basic" package that becomes a floor for the middle class and a ceiling for the poor. Pragmatically, a pared down uniform benefit package would only perpetuate the cost shifting and insurance risk segmentation that

undermine current efforts to contain costs. Similarly, if lower income populations are perceived to be financed from a "separate" pool of funds, arbitrary budget cutting becomes all-too-easy, exacerbating the cost shift from the public to the private sector.

II. RECOMMENDATIONS FOR IMPROVING COST CONTAINMENT IN THE PRESIDENT'S LEGISLATION

CHA supports many components of President Clinton's healthcare reform bill. We are especially pleased that he is calling for universal coverage, a uniform comprehensive benefit package, and a number of important protections for low income populations. With regard to cost containment, we commend the President for including in his proposal:

- **A framework for delivery reform** with incentives for health plans to organize themselves to operate within annual premium limits and to stress primary and preventive care.

- **Universal coverage achieved relatively quickly,** an absolute necessity for effective cost control because of the "vicious circle" of cost shifting described earlier.

- **Reliance on a uniform, comprehensive benefit package for all persons** regardless of income or health status--a feature that is essential if we are to put an end to the cost shifting and risk segmentation that plague our current system.

- **Overall expenditure control for much of the plan based on premiums or capitation** rather than rate setting. The President does rely on some rate setting for fee-for-service plans operating in the alliances, but we are pleased to see that the dominant mode of expenditure control is through premiums.

- **Consolidation of acute Medicaid financing into the Regional Alliances** which helps to prevent financial discrimination against the poor and a destabilizing cost shift from the public sector to the private sector.

Based on our extensive analysis of the cost containment issue, CHA urges Congress to strengthen the President's bill by 1) creating a sharper focus on delivery reform, and 2) developing a more realistic process for overall expenditure control in the form of a national budget.

1. Sharper Focus on Delivery Reform

The bill needs a much sharper focus on reform of the healthcare delivery system. CHA believes that the Integrated Delivery Network concept is essential for true, long term cost control in a reformed system. Without delivery reform, insurers will be encouraged to rely on *a la carte* discounting, rate setting, externally imposed utilization controls, and micro-management of providers in order to get the "quick" savings they need to live within premium caps. Some of these devices may, in fact, be appropriate. But to rely on them solely is a mistake. We believe that the insurance function should be merged with the delivery function in the form of integrated networks and that the focus should be on more efficient methods of organizing care, not simply clamping down arbitrarily on payments and utilization.

Several elements of the Clinton bill need to be changed to ensure effective delivery reform:

- **First, there needs to be greater emphasis on clinical and financial integration of care in the form of community-based, person-centered networks.** The proposal assumes and even encourages significant reliance on insurance companies to form and administer plans. This, in itself, is not a problem as long as the insurers act as partners with providers to create truly integrated locally-based networks. It does become a problem, however, if insurers act as distant regulators. This kind of arrangement may bring "quick" savings to the system and substantial profits for insurers, but it will not result in better coordinated

or more efficient care. Nor will it ensure long-term accountability to local communities.

- **Second, Medicare should be incorporated into the overall reform.** The Clinton legislation leaves Medicare out of the new financing arrangements. While the Health Alliances may encourage more integrated systems of care through annual per person payments, Medicare will perpetuate the opposite incentive by paying providers on a procedure-by-procedure basis. Thus providers will continue to face the mixed and counterproductive financial incentives that plague our current system. We can understand why Medicare may not be immediately folded into the Health Alliances, but we urge you to consider a fixed schedule and transition plan for bringing in Medicare to ensure consistent, stable incentives.

- **Third, long term care needs to be fully integrated with acute care.** We support the President in his expansion of long term care services to the disabled and elderly, but once again, sustainable cost savings will occur only if integrated networks can manage the full continuum of healthcare services, thereby allowing them to make patient-specific decisions about the most appropriate, most humane, and least costly patient care settings. Admittedly, local healthcare systems are not yet prepared to accept capitated payments for the full array of acute and long term care services, but reform should move the system in that direction through a target date and transition plan. Otherwise, we will perpetuate an artificial and costly bifurcation in what should be a seamless continuum of care for people in all stages of life.

- **Fourth, the financing schedule for the Clinton bill needs to be re-structured to ensure effective delivery reform.** Expenditures in the Clinton legislation are compressed unevenly and unrealistically fast. CHA fully supports the need to bring both private and public healthcare costs under control through a national healthcare budget. But the President's proposal calls for a faster compression for the two major public programs: Medicare and Medicaid. This will result in greater cost shifting between the public and the private sector, and could ultimately lead to severe access problems for the elderly. More importantly, total spending is brought down at an implausibly rapid rate that may well encourage "quick and easy" payment and utilization controls, but certainly will not allow time for the development of efficient, community-based healthcare networks. The reduction in spending increases envisioned in the Clinton plan may not be too much, but it is certainly too fast for effective delivery reform.

- **Finally, financing for low income populations needs to be directly linked to financing for the middle class.** The President's "caps" on subsidies for low wage workers violates this principle and could severely hinder delivery reform. If these caps result in further underfunding of the system, the President's bill will have further postponed the day when integrated delivery networks can bring true efficiencies to healthcare. If the caps result in inadequate access for low wage workers and the poor, we will once again be facing the vicious circle of cost shifting in healthcare, not to mention a failure to meet the needs of all Americans.

In short, effective cost control can only be built on a foundation of delivery reform. Without meaningful delivery reform, we are deprived of the tools we need to achieve the President's goal of effective cost control.

2. Process for Setting the National Budget

Our second recommendation for strengthening the President's legislation is to employ a more informed and realistic process for establishing a national budget. CHA's reform proposal calls for a "bottom up/top down" national budget-setting process that would incorporate critical information on population needs and local system efficiencies over time. Our plan likewise outlines a series of "checks and balances" that would help ensure direct and explicit accountability to voters for each year's national budget. As described earlier, for example, the National Health Board in our proposal uses data from local Health Alliances to recommend an explicit and visible national budget amount to Congress which must then act on it with an "up or down" vote.

In contrast, the President's bill calls for a "top down only" approach to a national budget as defined by a formula-driven rate of increase. In CHA's view, this approach misses an important opportunity to make healthcare expenditures not only

more predictable and reasonable, but also more consistent with changing health needs, system capacity, and the public's own view with regard to the tradeoffs between healthcare and other important social goals.

The President's legislation is also weakened in this regard because the National Health Board is structured not as an independent body, but as an agency under the President. This undermines the independence of the National Health Board and precludes the process we are describing whereby Congress is held accountable for a "yes or no" decision on an expertly determined budget amount for the year.

Mr. Chairman and members of this subcommittee, CHA strongly urges you to retain a national budget "backstop," but to use an informed process to determine the annual allowable increase in national healthcare expenditures. We also urge you to structure the National Health Board as an independent agency.

III. CONCLUSION

Let me conclude by offering a personal observation from my two-year tenure on the CHA Leadership Task Force on National Health Policy Reform. In one of our early two-day meetings with that group, we conducted an exercise whereby we designed an "ideal" local healthcare system for people and the community. For purposes of the exercise, we did **not** consider cost containment or financing issues--all of our attention went to the question: "What would make the best sense from the point of view of the patient?" The design we produced on that day back in 1991 was the initial version of the Integrated Delivery Network, a seamless continuum of care

oriented toward the needs of individuals, families, and communities.

What I found instructive were the next steps in our deliberations as a Task Force. The more we developed the financing approach to our reform proposal, the more we realized that, when linked with capitation, our "ideal" delivery system simultaneously addressed **both** the quality **and** the cost issue. An integrated delivery network is a way to simultaneously meet the need for clinically effective, coordinated care **and** more cost-effective care. My hope is that this is a combination you too can encourage and support over the next several months as you work on Americans' behalf for a more secure healthcare future.

Thank you.

Mr. WAXMAN. Dr. Coleman.

STATEMENT OF WILLIAM H. COLEMAN

Mr. COLEMAN. Thank you, Mr. Chairman. My name is Bill Coleman. I am a rural family physician from Scottsboro, Ala.

It is my privilege to serve as current President of the American Academy of Family Physicians. I appreciate this opportunity to share with you our views on the cost-containment provisions in President Clinton's health reform proposal.

In 1989, the Academy became the first physician organization to develop a plan for universal access. With revisions made to "Rx for Health" in April 1992, the Academy took a position in support of enforceable health care costs containment. We took this position for two main reasons. The first reason relates to universal coverage cannot be achieved without reining in health care costs.

If we are to be serious in our commitment to universal coverage, then we must be absolutely serious in our commitment to controlling costs.

The second reason relates to the amount of waste in the health care system. You are aware of the data on the number of unnecessary health procedures and on the percentage of our GDP going to health care.

We view the waste from a somewhat different perspective. What we see are patients whose care is wastefully mismanaged as they ping-pong through a highly fragmented and sub-specialty dominated medical care system or whose care is expensively and often tragically delayed because they lack health insurance.

This waste has persisted not because health care providers are incapable of efficiency, but because they have never faced any real incentive to be efficient.

In developing "Rx for Health," considered carefully how best to achieve real cost containment. When we looked at other developed countries, the only consistently successful mechanism for controlling health care expenditures has been global budgeting. Global budgeting may not be the only way to control costs, but it is the only one that has a documented record of success.

The cost-containment strategy proposed in "Rx for Health" has much in common with the President's plans. Both would force a thoughtful consideration of how health care services are delivered. They stand in sharp contrast to the current situation which is devoid of any meaningful incentives for cost containment.

With an explicit global budget, it becomes necessary to carefully define need, appropriateness, and cost-effectiveness in rational and defensible terms.

In the absence of a budget, there is no accountability for allocation decisions; and too often, services are rationed in the cruelest way imaginable, on the basis of ability to pay.

We urge you to carefully assess any assertions that one solution or another will lead to rationing. The question needs to be asked: Compared to what?

Of crucial importance to a global budget it is how it is implemented and the tools that physicians are given to control expenditures. The President has recognized this by proposing a number of

structural changes in the health care system, the most important of which is placing a far greater emphasis on primary care.

Many of the Nation's cost problems can be traced to the over-specialization of American medicine. Other changes are designed to foster competition by creating a choice of health plans, specifying a standard set of benefits, requiring a basic set of quality and price information with which to compare plans, and increasing individual price sensitivity.

We are intrigued by the President's incorporation of these managed competition principles, and we think that enhanced competition may provide added incentive for providers to live within a budget.

However, we do not think that there is sufficient evidence to rely solely on managed competition as a mechanism to achieve cost containment.

As I said, cost containment is an absolute prerequisite to ensuring universal coverage and, therefore, too important to leave as an untested strategy.

In an enterprise as large and complex as health reform, there are bound to be some differences of opinion; and, indeed, there are a few areas where we believe the President's global budgeting mechanism can be approved.

For example, the President proposes to establish that per capita baseline for each alliance. We are concerned that the proposed method will incorporate unjustified historic variation in health care expenditures. Areas such as rural communities and inner cities have had low per capita spending and, as a result, are typically underserved.

We strongly believe that achieving equity in excess will require the elimination of all unexplained and inappropriate variation in health spending. We are pleased to see in the final legislative draft a stronger commitment to dealing with regional variation in health care expenditures.

Another area of concern is the mechanism for recouping premium increases that exceed the target for each alliance. According to the plan, assessments are imposed on "noncomplying" plans and, in turn, on providers receiving payment from those plans.

Our reading of the language suggests that these assessments must be applied uniformly across all providers. We believe that, instead, the plans must be given the flexibility to improve provider assessments in a manner that reflects the relative contribution of different providers to the budget overruns.

Plans should determine the reason that the premium exceeds the target and then make the assessments according to that determination.

For example, if the excess spending is attributable to hospital inpatient days or medical procedures, then the assessments should be charged the providers responsible for the excess cost. Otherwise, providers not responsible for inappropriate increases will be penalized for behavior that is not their own.

Mr. WAXMAN. Thank you. The rest of the statement will be in the record.

[Testimony resumes on p. 322.]

[The prepared statement of Mr. Coleman follows:]

STATEMENT OF WILLIAM H. COLEMAN, PRESIDENT,
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Mr. Chairman, my name is William H. Coleman, M.D., Ph.D. I am a rural family physician from Scottsboro, Alabama, and it is my privilege to serve as the current president of the American Academy of Family Physicians. It is on behalf of the Academy's 75,000 members that I express sincere appreciation for the opportunity to appear before the subcommittee and provide you with the Academy's views on the cost-containment provisions in President Clinton's health system reform proposal.

Background

Since the mid-1980s the issue of universal health insurance coverage has been of central importance to the Academy. At that time, the primary impetus for national concern was the growing number of uninsured people and their inability to access appropriate care. Studies documented what family physicians have long known: people who delay seeking medical care have higher morbidity and mortality and are more costly to treat. As the percentage of the gross domestic product spent on health care in this country has escalated, national attention on the problem of access has shifted to an equivalent concern about cost. The American Academy of Family Physicians shares these dual concerns.

Responding to our membership's concerns, in 1989 the Academy became the first physician organization to develop a plan for universal access through a public-private effort, building on the current model of employer-based insurance. In April 1992, the Academy released its revised and expanded plan for health reform, *Rx for Health: The Family Physicians' Access Plan*.

Rx for Health calls for universal access to a comprehensive set of benefits that emphasize primary and preventive care. It builds upon the present employer-based system and requires all employers, including small businesses, to provide insurance to their employees and dependent family members. Employers pay a specific portion of the premium. Employee cost sharing varies according to income. Better management of patient care is emphasized. A key element of the Academy's plan calls for each person to have a personal physician in one of the generalist specialties (family practice, general internal medicine or general pediatrics). Increased cost sharing is incurred if an individual seeks non-emergency subspecialty care without referral from the personal physician. *Rx for Health* includes specific strategies for moving toward a physician supply that is balanced between generalists and specialists. Furthermore, it calls for improved quality utilizing practice parameters and malpractice reforms, including caps on non-economic damages. And, to address spiraling health care costs, it includes stringent cost-containment provisions. A national health board is established and has the authority to set and enforce a global budget. Enforcement is targeted specifically to those segments of the health care system responsible for inappropriate spending increases.

With the release of *Rx for Health*, the Academy established its firm support of enforceable health care cost-containment through the application of a global budget. We took and continue to adhere to this position for two main reasons. First, ensuring universal health insurance coverage, which is everyone's bottom-line goal for health reform, cannot be achieved without reigning-in health care costs. If we are to be serious in our commitment to

universal coverage, then we must be absolutely serious in our commitment to contain runaway health care costs. Any proposal to provide universal coverage that does not contain enforceable cost-containment is simply not credible.

The second reason relates to the amount of waste in our current health care system. You have seen the studies. You have been presented with evidence that twenty to thirty percent of medical procedures may be unnecessary, and you have seen the data showing that the United States spends thirty to fifty percent more of its gross domestic product on health care than any other developed country without even achieving universal coverage. What we see on a daily basis is the impact of waste on a more micro level. On one hand, we see patients whose care is wastefully mismanaged as the are ping-ponged through a highly fragmented and sub-specialty dominated medical care system. One the other hand are patients whose care is expensively and, often, tragically delayed because they lack health insurance and access to primary care. This excessive waste has persisted not because health care providers are incapable of efficiency, but because they have never faced any real incentive to be efficient. We urge you to change this.

In developing *Rx for Health*, we searched for the best mechanisms for achieving real cost-containment. Our strategy, like many other proposals, is multifaceted. We have proposed various administrative simplifications, professional liability reforms, expansions in primary and preventive care, and structural reforms designed to improve the management of patient care. However, as important as each of these individual reforms might be, we do not believe real cost-containment can be achieved without a mechanism that over-arches the entire health care system. When we looked at other developed countries, it was readily apparent that the only consistently successful mechanism for controlling health care expenditures is global budgeting. It may not be that global budgeting is the only mechanism that can control costs, but it the only one that we found to have a documented record of success.

The cost-containment strategy proposed in *Rx for Health* is not unlike that in the President's plan. A national health board would determine national cost containment objectives and oversee private and public efforts to achieve those objectives. State and local health plans would retain the ability to develop and implement specific cost containment mechanisms within the context of the broad objectives established by the national health board. Relative to cost-containment the national board would:

- collect and disseminate profiling data including measures of the volume and intensity of health care services and factors that affect volume and intensity (a high priority for the board would be to promote the development of measures of factors that affect health care spending and that might warrant consideration in evaluating the success of health plans in controlling health costs;

- establish a national budget for aggregate health care spending expressed in terms of a rate of annual growth in spending for health care services;

- enforce compliance of state and local health plans with the national budget for health care spending and the aggregate performance standard rate of growth;

- establish annual performance standard rates of growth for each major component of health care spending (in general, these component performance standards would be advisory, however, the board could direct a health plan to follow the nationally established component performance standards to limit plan expenditures in a year when aggregate spending under that plan exceeds the allowable rate of growth); and

- provide technical assistance to plans in order to examine the factors contributing to increased health care spending within each component performance standard and develop remedial actions to address those factors contributing to excessive cost increases.

The Aggregate Performance Standard for health care spending growth would be binding for all state and private health plans. Health plans and their participating providers would be free to negotiate their own component performance standards in order to meet the national aggregate performance standard. In addition, a plan meeting the national aggregate performance standard for spending growth could negotiate higher conversion factors or bonus payment arrangements with its providers. However, if a health plan's aggregate spending growth exceeds the national aggregate performance standard, the ability to negotiate independently component performance standards and fee increases with providers would be constrained. In such a case, increases in provider fees could be limited according to their performance under their respective nationally established component performance standards.

Evaluation of health plans' performance would take into account differences in the age of plan enrollees. In addition, as data become available the national health board would provide for an exceptions process for health plans that can demonstrate cost increases attributable to "uncontrollable" factors such as unfavorable risk selection among plan enrollees or epidemiological changes.

The cost-containment strategies proposed in *Rx for Health* and in the *Health Security Act* would force a thoughtful consideration of how health care services are delivered. These proposals stand in sharp contrast to the current situation in which we find ourselves, a situation devoid of any meaningful incentives for cost-containment and one in which, by default, health care resources are too often rationed on the basis of the ability to pay. Within the current health care debate, the specter of rationing is often raised in the context of global budgeting. We think this a misuse of the term. With universal access and an explicit global budget, it becomes necessary to carefully define need, appropriateness, and cost-effectiveness

in rational and defensible terms. In the absence of a budget, there is no accountability for allocation decisions, and too often services are rationed in the cruelest way imaginable, on the basis of the ability to pay. We urge you to carefully assess any assertions that one solution or another will lead to rationing. The question needs to be asked, "Compared to what?"

The Clinton Plan

Based on a preliminary review of the *Health Security Act*, the Academy supports the principles and many of the strategies espoused in the Administration's health reform proposal. The draft plan provides a positive framework for considering the many complex issues entailed in health system reform. Academy members are particularly pleased with the commitment of the President to universal access to a set of comprehensive benefits that include preventive services and prescription drugs and that provide a good start on mental health coverage. These are services often overlooked in insurance benefit packages. As deliberations on reform continue, these elements must not be compromised. Everyone in the United States must have access to comprehensive, affordable, high-quality health care services.

As with any proposal as expansive and complex as the *Health Security Act* we are not in perfect agreement with every aspect of the plan. In the remainder of my testimony I will discuss the specific the cost-containment strategies proposed by the President and share with you the Academy' views on where those strategies could be improved.

In the area of cost-containment, the President has adopted a broad-based set of strategies. However, the President's basic cost-containment strategy is a global budget that is enforced through limits on increases in health insurance premiums. Generally speaking, we think this an appropriate approach and one that is backed-up by international experience. As you undoubtedly realize, a global budget works by transferring to health plans and to providers the financial risk of expenditure increases that are in excess of the budget target. The President's plan works in exactly this way. Health plans are assessed for premium increases and expenditures that exceed targets set for each alliance. These assessments are then passed along to providers. Under our current system, that risk in borne by payers and, ultimately individual insureds.

Of crucial importance to the application of global budgets are the specific mechanisms by which they are implemented and the tools that physicians and other providers are given to enable them to provide universal access to high quality health care services within the confines of a global budget. The President has recognized this by proposing a number of structural changes in the health care system. Some of these changes are designed to foster competition by creating a choice of health plans, standardizing the comprehensive benefit package across health plans, providing a basic set of quality and price information with

which to compare plans, and increasing individual sensitivity to price differences. We are intrigued by the President's incorporation of some of the principles of "managed competition," and we think that enhanced competition may provide added incentive for providers to live within a global budget. However, we do not think that there is sufficient empirical evidence to rely solely on managed competition as a mechanism to achieve real cost-containment. Cost-containment is an absolute pre-requisite to ensuring universal coverage and, therefore, too important to leave to a largely untested strategy.

Budget Development and Enforcement

The President proposes to establish a per capita baseline target for each alliance based on the national per capita baseline target adjusted for current regional variations in health care spending and for rates of under- and un-insurance. Measures of regional variation may include variations in premiums, variations in per capita health spending, variations in per capita Medicare spending, and other factors commonly used by actuaries. The Academy is concerned that the proposed method for establishing a per capita baseline premium target for each alliance will incorporate unjustified historic variation in health care expenditures. Areas with low per capita health spending are typically characterized by poor access to health care resources.

Family physicians tend to locate their practices in rural areas, and, as a result, have had first-hand experience with the consequences of geographic variation in spending. We believe that the low per capita health care expenditures of rural people reflect low rates of insurance coverage and the incorporation of historically depressed payment rates in physician and hospital payment formulas. These low payment rates have persisted despite the fact that the cost of practice is no lower in rural areas than in urban areas. Low rural payment rates are largely responsible for the shortage of health care providers in rural communities. The Academy sought a remedy for these historically low rates in the Medicare physician fee schedule. Unfortunately, we were not successful. The geographic adjustment factor perpetuates the traditional urban-rural differential in payments, and, as a result, the disparity in the supply of physicians between urban and rural communities grows larger.

We understand that minimizing the disruption of health system reform may require that initial premium targets reflect current spending patterns. However, we strongly believe that achieving equity in access across all alliances will require the elimination of all unexplained and inappropriate variation in per capita premium targets.

We were pleased see in the final legislative draft a substantial strengthening in the section (Sec. 6006) dealing with regional variation in health care expenditures. A specific process is laid out for examining regional variation and for recommending appropriate adjustments. An advisory commission to the National Health Board is to explore methods of reducing geographic variation in budget targets due to differences in practice patterns, physician

supply, population characteristics, and other factors. Adjustments to targets require Congressional approval.

According to the plan, if an alliance's anticipated weighted-average premium exceeds its per capita budget target, an assessment is imposed on each plan whose premium increase exceeds the alliance's premium inflation factor. Assessments are then imposed on "non-complying" plans and on providers receiving payment from those plans. Our reading of the legislative language (Sec. 6012) suggests that these assessments must be applied uniformly to all participating providers. We believe that plans must be given the authority to impose provider assessments in a manner that reflects the relative contribution of different sectors to the budget over-runs. Plans should determine the reason that the premium exceeds the target and then make the assessment in accordance with that determination. For example, a thorough analysis should determine whether premium increases are attributable to hospital inpatient days, medical procedures, pharmaceuticals, or other types of services. Assessments should then be made to the providers responsible for the excess premium increases. Otherwise, providers not responsible for inappropriate increases will be assessed in the same manner as other providers and, therefore, be penalized for behavior not their own.

National Inflation Factor

The President's health reform proposal limits the annual growth in premiums to a national inflation factor (Secs. 6000 and 6001). The inflation factor in 1996 is specified as the projected increase in the Consumer Price Index (CPI) plus 1.5 percentage points. The inflation factor subsequently decreases in equal increments to reach CPI in 1999 and each year thereafter. We are concerned that the decrease to CPI may be an unrealistically stringent limit on growth in health insurance premiums.

As noted above, family physicians are extremely concerned about the amount of unnecessary, inappropriate and overly-expensive care that is rendered in the American health care system. While there is a great deal of waste in the system, there no readily available mechanism to recapture those wasted dollars and redirect them to improving access and quality, especially in the short run before delivery system reforms have been fully implemented. In the longer term, CPI may still be an unrealistic standard. Some allowance must be made for scientific advancements and improvements in our ability to treat conditions for which remedies do not currently exist. In addition, changes in basic population characteristics, such as immigration, fertility, and aging, and epidemiologic trends, such as an increase in the incidence of AIDS, may bring about changes in the need for health services that are unrelated to CPI. We are pleased to note that the legislative draft directs the National Health Board to recommend adjustments to the national inflation factor for the years beginning with 2000.

Malpractice Reform

Concerns about malpractice contribute to the growth in health care costs directly through excessive premium, award, and administrative payments and indirectly through the induced practice of defensive medicine. The provisions in the President's plan addressing malpractice concerns are consistent with those supported by the Academy, but it is silent on two effective strategies that have been utilized in state malpractice reforms: the limit of payments for non-economic damages and a statute of limitations for filing a claim. Additionally, we believe that the proposed alternative dispute resolution mechanism would add more administrative burden than it would eliminate.

We suggest the ADR mechanism be modified so that at the completion of the alternative dispute process, if one of the parties in the dispute wishes to challenge the outcome, he or she may do so in court. However, if the decision rendered in court is less favorable than that in the alternative dispute resolution, he or she should pay all legal fees.

We recommend that the statute of limitations be modified so that a claim must be filed within two years from the date that the alleged injury should have reasonably been discovered, but in no event more than four years from the time of alleged injury. In the case of alleged injury to children under age six, a claim must be filed within four years from the date that the alleged injury should have reasonably been discovered.

In regard to limits on non-economic damages a limit of $250,000 should be established.

Physician Supply

The Clinton plan clearly recognizes the need to enhance the availability of primary care. We view this as a structural change of fundamental importance to achieving real cost-containment and universal coverage. While much has been said in recent years about the shortage of generalist physicians (family physicians, general internists and general pediatricians) the rhetoric is often unmatched with action. A notable exception has been the Chairman's introduction of HR 2804.

We are particularly pleased that the Clinton plan focuses attention on and identifies specific strategies for achieving a more appropriate balance of generalist and specialist physicians (Secs. 3031-3034). Physician workforce goals must reflect the health care needs of the population. Correcting the problems of specialty imbalance in the system will require significant changes in current federal policies and aggressive interventions. These efforts are controversial as they challenge the status quo, but they are essential if we are to achieve universal access to comprehensive health benefits. This will be one of the most difficult and challenging legislative issues. While many offer rhetoric on the need for more generalists,

few are willing to take meaningful action. The strong message currently in the Clinton plan regarding the physician workforce is critically important.

Primary care

As this committee considers issues related to the physician supply we urge that the concept of primary care not be trivialized. A primary care physician (or generalist physician) provides definitive care to the unselected patient at the point of first contact. Such a physician will have been specifically trained to provide primary care services, usually through completion of a residency in family practice, general internal medicine or general pediatrics. Primary care physicians devote the substantial majority of their practice to providing primary care services to a defined population of patients. The style of primary care practice is such that the personal primary care physician serves as the first point of contact for substantially all of the patient's medical and health care needs.

Occasionally, individuals who are not trained as primary care physicians will provide patient care services within the domain of primary care. These limited primary care providers may be physicians from other specialties, nurse practitioners, or physician assistants. Such providers may focus on patient care needs related to prevention, health maintenance, acute care, chronic care, or rehabilitation.

The contribution of limited primary care providers may be important to specific patients. However, the absence of a full scope of training in primary care and limited practice skills in providing the full range of primary care services requires that such providers work in close consultation with fully trained primary care physicians. Effective systems of primary care will use limited primary care providers as adjuncts to the health care team with primary care physicians taking responsibility for the total care of each patient.

We note with some concern that the final legislation includes obstetrician-gynecologists in the definition of primary medical care. The fact that Ob-gyns provide certain services that are within the domain of primary care is well recognized. Furthermore, we recognize that many women have the majority of their health care encounters with Ob-gyns during certain periods of their lives. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in Ob-gyns. As defined by the Council on Graduate Medical Education, primary care entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature, and care that includes the coordination of other health services. In its fullest sense, primary care includes the assessment and evaluation of signs and symptoms initially presented by the patient, the management of acute and chronic medical conditions, the identification and appropriate referral of conditions requiring specialized care, and the provision of health promotion and disease prevention services. While a number of providers receive training in and typically provide some

important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. We note that the Ob-gyn literature clearly acknowledges the limited role of Ob-gyns in the provision of primary care.

As the definition of primary care is used in the President's health reform plan, it dictates a substantial redirection of training funds. Because the role of Ob-gyn in primary care is limited, we are very concerned that efforts to improve access to primary care will be compromised by including Ob-gyns in the definition of primary care. Increasing the training funds for Ob-gyns will not substantially improve the number of providers of primary care services. Furthermore, including Ob-gyns in the definition of primary care suggests that there are available many more primary care physicians than is, in fact, the case.

We understand that many women may, by personal preference, choose to have a majority of their health care from an obstetrician-gynecologist during certain periods of their lives. We support the continued opportunity for women to make that choice. This is clearly an option that will be preserved under the fee-for-service plans and point-of-service options. We expect that many managed care entities will allow women to utilize Ob-gyns routinely. What is at issue for the Academy is improving access to primary care services. An important part of addressing this issue is training more primary care physicians. We believe this best accomplished by leaving undiluted the current definition of primary care (family medicine, general internal medicine, and general pediatrics).

As you consider the definition of primary care we would urge the committee to pose the following questions to the Ob-gyn community:

- What percentage of currently practicing Ob-gyns spend the majority of their clinical practice providing services in the domain of primary care?

- If all Ob-gyns are classified as "primary care providers," how will the Ob-gyn community assure women that a specific Ob-gyn physician is both willing and competent to serve as her primary care physician?

- If Ob-gyn, as a specialty, is classified as "primary care," in what ways and how rapidly will Ob-gyn residencies redirect their training from the current emphasis on surgical specialty training towards the full competencies of primary care providers?

Unless you are satisfied by the answers to these questions that Ob-gyn will truly function as a primary care specialty in the future, we would urge you not to change their specialty designation as has been done in the President's plan.

Non-physician providers

As the challenge of moving toward an appropriate balance of generalists and specialists in the physician supply is addressed, the related issue of the role of non-physician providers in the health care system emerges.

The President's proposal directs the Secretary of the Department of Health an Human Services to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants (Sec. 3062). In addition, Section 1161 provides that no state may restrict the practice of any class of provider beyond what is justified by skills and training.

No topic that we will address in this testimony presents more difficulty to a physician. We recognize that it is all too easy to read into these words an attempt to simply protect professional "turf." Allow me, therefore, to note that no other physician specialty is as likely to engage in collaborative practice with non-physician providers. We fully appreciate the substantial contribution of non-physician providers to the delivery of primary care. Furthermore, our members are cognizant of the fact that many state laws impose undue restriction on the practice of non-physician providers. We approach this issue supporting the expanded utilization of non-physician providers and the elimination of undue barriers to their practice.

It is our understanding that some within nursing community seek an explicit pre-emption of any state practice act that preclude nurses from providing the full range of primary care services independent of physician supervision. We believe that the current language provides sufficient means to address unwarranted barriers to the practice of non-physician providers and, furthermore, the current language avoids unnecessary consequences that would accompany a federal pre-emption. Pre-empting state practice acts would constitute an unwarranted federal intrusion in an area of traditional state jurisdiction and may result in adverse consequences for both the cost and quality of care.

The substantial abilities of nurses to provide certain high-quality services that are within the domain of primary care is well recognized. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in any of the non-physician practitioners. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. (See also the comments above on obstetrics and gynecology as "primary care physicians.")

We find the call for the unsupervised practice of primary care by non-physician providers unsupported for a number of reasons. First, while generally positive in its findings, the

available research on the quality of care and cost-effectiveness of non-physician providers is limited in the scope of services examined, employs a narrow-range of quality measures, and provides no basis on which to judge the quality and cost-effectiveness of unsupervised practice. All of the studies of which we are aware examined non-physician providers practicing **with** physician supervision. The claim that unsupervised non-physician providers can provide the full range of primary care services with physician-like quality has absolutely no basis in research.

Second, the Academy notes that the call for independent non-physician provider practice comes from a relatively narrow segment of the non-physician provider community. The physician assistant profession has explicitly rejected independent practice. The non-physician providers with whom family physicians work, especially those who practice in remote settings without on-site supervision, do not consider independent practice to be professionally responsible. They, as well as their patients, need to know that when confronted with a serious or confusing medical condition, a responsible supervising physician is immediately available to provide either consultation or direct intervention. Anything less risks compromise in the quality of care.

Health Research Initiatives

An important aspect of cost-containment is enhancing the availability of preventive services and ensuring the appropriateness of medical services. The President's plan is to be commended for its coverage of preventive services. In addition, the President's plan provides substantially increased research funding in the areas of disease prevention and health services research (Secs. 3201 and 3202).

While these are important areas of research, the draft plan omits a highly relevant and to-date largely ignored research area, family practice and primary care research. For the past thirty years, over 95 percent of all medical conditions have been evaluated and treated outside of hospitals. However, the traditional focus of medical education and research has been on medical problems in referred and hospitalized patients. Thus, the training of physicians and the research agenda have focused almost exclusively on inpatient rather than outpatient evaluation and treatment.

Because the National Institutes of Health has not in the past and does not now include primary care research, and because the limited resources and other priorities of the Agency for Health Care Policy and Research have precluded all but the most limited attention to it, we believe that it is imperative to identify family practice and primary care research as a priority in health system reform.

The draft plan placed considerable attention on effective strategies to emphasize training of generalist physicians in ambulatory settings to meet the considerable demand for primary

care services. However, the research initiatives portion of the plan is deficient in the comparable area of research. We therefore suggest that a third focus for new funding for health research be specified as family practice and primary care research.

Family practice and primary care research relates to better assisting the generalist physician in diagnosis and treatment of the undifferentiated patient population treated in the ambulatory care setting. The Agency for Health Care Policy and Research and/or the National Institutes of Health should initiate and expand office-based, community-oriented family practice and primary care research in priority areas including:

- Research to better understand the role of diagnosis in family practice and primary care to assist the generalist physician to evaluate the myriad symptoms of the patient, differentiate self-limited diseases from those requiring ongoing or intensive treatment and initiate effective treatment. The tangible benefits of such research could streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.

- Research to improve the effectiveness of medical care as the physician, in collaboration with the patient designs and implements an effective treatment that reconciles the idiosyncracies, preferences and the needs of the patient with the realities of the illness.

- Research to improve access to health care and the cost-effectiveness of care focusing on the role of front-line, generalist physicians."

Conclusion

The time has come for comprehensive health system reform, including serious cost-containment. This will be challenging for the Congress, the Administration, health care providers, businesses, and patients. Change, even positive change, is always difficult. However, the status quo is no longer acceptable. The American Academy of Family Physicians looks forward to working with you to achieve the positive change that we all seek.

I thank you again for this opportunity to appear before you and would be pleased to answer any questions.

Mr. WAXMAN. Dr. Schenken.

STATEMENT OF JERALD R. SCHENKEN

Mr. SCHENKEN. Thank you, Mr. Chairman.

As this Nation moves toward reform of our health care system, there is little disagreement that steps need to be taken to restrain and, in some cases, reduce or eliminate some of the costs associated with providing health care. The key is to make sure that needed services are continued.

For a physician, the cost of health care is not necessarily the first thing they think about when a patient comes through the front door of his or her office. Physicians must first look to the medical needs of the patient. Cost must come far behind our patient's well-being. That is how it should be. Physicians don't treat global patients—they treat them one at a time.

From the psychiatrist to helps a severely depressed patient to the orthopedic surgeon who rebuilds a knee, physicians help Americans be productive, positive participants in both our economy and society at large. The quality and value of life is improved in immeasurable ways.

It is also true that labor-intensive health care is a service that, as currently financed, has not conformed easily to economic models. New and improved technologies don't necessarily lower costs, to the system and can act as an accelerant by improving our ability to provide care and increasing the number of people who want that care.

What is the cost to an incapacitated person, say, Bo Jackson, who waits for an artificial hip which may or may not come?

When it is a family member who would benefit, we want nothing but the best, latest medical intervention.

It should also be recognized that the private sector has been aggressive, and often successful—and you have heard about that today—in addressing some of the increases in health care costs.

In the face of these difficult, complicated issues, the President's plan offers a worrisome level of control and regulation designed to affect, primarily, the supply side of the health care cost problem.

The seven members of the National Health Board—none of whom are physicians—will be responsible for developing insurance premium price controls. Premiums would only be allowed to increase only by increases in the CPI, GDP, other population measures.

Under health system reform, more individuals will want—and deserve—more health care services. But it is difficult to see how the health care market will be able to provide that care if it is not allowed to expand nationally to meet those people's needs.

While it may be argued that fee-for-service systems have incentives for excess utilization, it may be comparably argued that capitated HMO plans have incentives for under-utilization. Neither is necessarily true, but both implications must be considered.

Price controls have never been successful in controlling increases in spending, no matter what the setting.

Spending increases must be attacked with reform strategies on the basic causes of increased spending, not just its symptoms.

Critical issues which increase demand—such as new technology, public expectations, liability exposure, life-styles of both the individual and the community, the aging population, the tax treatment of health benefits, and the third-party payment system itself—must be addressed by everyone, not simply by physicians.

With a better competition that will result from an enhanced insurance of health care market, predictable spending can be used to heighten the awareness of spending patterns and set the focus for refining cost-containment aimed at identified, unwarranted spending.

Outcomes, research, practice parameters, and aggressive technology assessments—things AMA has been doing for many years—linked with the professional judgment of the individual physicians are the best ways to curb inappropriate utilization.

But remember technology assessment is one thing, but technology utilization, one patient at a time, is quite another.

There are other areas of cost savings that can and must be addressed—as I have mentioned before.

Prevention that includes life-style modification and a firm commitment to deal with the violence that pervades our society; administrative costs; cost consciousness and competition, including disclosure of price information to patients by physicians; liability reform; and antitrust relief to allow physicians to curb those physicians who charge too much; and so forth.

Mr. Chairman, there are better ways of controlling cost than placing an arbitrary cap on the Nation's health expenditures.

If there is one thing we know about the health care costs, it is that they are unpredictable.

But the means of limiting these expenditures must take into account the patients' needs.

We promise our cooperation in the efforts of the subcommittee, Congress, and the administration to help determine those means.

Thank you.

Mr. WAXMAN. Thank you.

[Testimony resumes on p. 335.]

[The prepared statement of Mr. Schenken follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Energy and Commerce

Subcommittee on Health and the Environment

U.S. House of Representatives

Presented by: Jerald R. Schenken, MD

Re: Containing Health Care Costs

November 8, 1993

Mr. Chairman and Members of the Subcommittee:

My name is Jerald R. Schenken, MD. I am a physician in the practice of pathology in Omaha, Nebraska. I also am a member of the Board of Trustees of the American Medical Association (AMA). Accompanying me is David L. Heidorn, JD, of the AMA's Division of Federal Legislation. AMA is pleased to have this opportunity to testify today on the many issues that are characterized by the phrase "health care costs."

As we move to reforming our nation's health care system, there is no disagreement that steps will need to be taken that will restrain and in some cases reduce or eliminate some of the costs associated with providing health and medical care.

There is no disputing that our nation spends a large amount for health care services. The figures are well accepted: close to 15% of our gross domestic product and nearly $1

trillion dollars in annual expenditures. Having said this, I want to take a step back and let you know that physicians do not think about total national health expenditures or percentage of GDP attributed to health when a patient comes through the door. The physician, the nurse, and other health care professionals look to the needs of their patients. There are over 7,000 distinct medical services that a physician can provide, and our patients often are in need of multiple services. Correspondingly, there are more than 500 diagnoses for which a patient may be receiving treatment in a hospital. While some may talk of health care in terms of cost and dollars, physicians look at this in terms of meeting the needs of their patients one patient at a time. When physicians provide care, they do far more than consume resources that are represented as a share of the gross domestic product. They evaluate their patients' medical conditions and develop a diagnostic or treatment plan designed to help patients. This is repeated across the land every day by my colleagues, and society and the economy benefit from these services, from the psychiatrist who is able to aid a severely depressed patient in returning back as a productive member of the workforce, to the orthopaedic surgeon and team of health professionals who perform the medical miracles that have enabled working Americans to return to their jobs. Beyond the quantitative benefits to the economy of a healthier workforce, patients benefit through improved quality of life.

The debate on the future of our health care system must recognize that dollars spent on health care provide a service that people, our patients, want. And, in truth the costs associated with providing this care also should not be unexpected. These costs historically have risen at a rate above the rate of growth in the GDP, the consumer price index, and other economic measures. It's a simple economic fact that health care, much like educational

expenses, is provided through the service component of our economy, is labor intensive and does not lend itself to the mass production as used in the production of goods. Also, new and improved technologies act as an accelerant by improving our ability to provide care.

During the past 30 years, medical technology has played a direct role in major improvements in the health status of the average American. These increases in longevity and improved quality of life are not without a cost. Physicians see what these new technologies can do for our patients. We know that innovative medical technology helps people live healthier, longer lives. We know that, when it is our patients and their loved ones who are sick and in need of medical treatment, they want only the latest, most advanced medical care available.

Few of us would act any differently. The positive effects of technological advances related to health care are enormous. For example:

- shortening recovery periods -- surgeons now increasingly can use a laparoscope for operations, such as a cholecystectomy, requiring only a very small incision and dramatically shortening the recovery period;
- improving functional outcomes -- prosthetic devices have restored function to patients who previously had been incapacitated by advanced arthritis, fractures, and bone disorders;
- allowing earlier diagnosis -- mammograms allow earlier detection of breast cancer, improving the survival rate;
- drugs substitute for surgery -- drug therapy has been effective in allowing some patients with ulcers, gallstones, coronary artery disease, and hyperthyroidism to

be treated without surgery; and

- improving the population's general health -- vaccines and new pharmaceuticals have virtually eliminated deaths in the US caused by polio and pertussis; smallpox has been eradicated from the face of the earth; the Hib vaccine is effective in preventing meningitis infections in children under age one (those with the highest infection rates); and the development of assays for detection of HIV antibodies in the sera of blood donors now routinely saves transfusion recipients from HIV infection.

No one would want these advances to go away. Where there are questions on the application of technological and other advances, the focus should be on proper utilization of technology and other care options.

It should also be recognized that the private sector has been aggressive in addressing health care cost increases and many of these efforts are coming to fruition, with a significant drop in the rate of increase for health care spending. For example, in Southern California, Mr. Chairman, aggressive health care plans have changed the face of health care delivery as they evolve through the third and fourth generations of managed care.

While recognizing these paradigm shifts, the President's plan still maintains an unacceptable level of control and regulation designed to effect mainly the supply side of the health care market. The National Health Board, 7 members none of whom must be a physician, will be responsible for developing insurance premium price controls that could have profound effects on health care delivery in this country. For example, the plan that went to the Congress would allow premiums to increase only by increases in the CPI, GDP and

population, failing to recognize the unique input costs in the health care sector that would remain uncontrolled. Likewise, attempts to deal with the demand side of the equation would be counteracted by the proposal to eliminate any balancing billing under the Medicare program, thereby lowering the price of services. When prices go down, demand usually goes up. We would urge the Subcommittee to consider the AMA's basic benefit package as a less costly alternative to the coverage provided for in the President's plan.

Practice Parameters and Technology Assessment

That is not to say that there are still not areas where savings can be achieved. As we learn more about the biological process of disease and injury, we better understand the interventions that have the greatest possibility of success. The emerging field of outcomes research will provide us with valid data as to the success of various treatment approaches. As part of this process, the development of practice parameters and aggressive technology assessment are the best means to curb inappropriate utilization. Practice parameters are strategies for patient management developed to help physicians make clinical decisions. Parameters help clarify appropriate utilization of technologies, resulting in better patient care. When combined with the professional judgement of the physician, parameters are an effective strategy.

The AMA, in conjunction with other medical societies, has established the AMA/Specialty Society Practice Parameters partnership and the Practice Parameters Forum, which direct and influence medically appropriate development and implementation of parameters. By providing recommendations on the optimal management of specific clinical conditions, practice parameters have the potential of enabling physicians and other health care

professionals to enhance their professional performance and improve patient care. By way of example:

- practice parameters for performance of cesarean (C-Section) have resulted in a decrease in C-Section rates with no increase in fetal or maternal morbidity or mortality;
- practice parameters on proper timing of prophylactic antibiotic administration have been correlated with a 50 percent decline in incidents of deep postoperative wound infections;
- practice parameters for monitoring patients during general anesthesia have resulted in a marked reduction in the incidents of hypoxic injuries;
- practice parameters for cardiac pacemakers have resulted in a significant decline in pacemakers utilization rates; and
- practice parameters for transfer of cardiac patients from coronary care units have improved utilization of these units.

In endorsing the use of practice parameters, we must caution that they are not a cookbook as to what care should or should not be provided in all instances. However, they do provide valuable guidance and they have been demonstrated to have an impact on the cost of care.

Technology assessment studies the safety, effectiveness, indications for use, and cost effectiveness of technologies. The AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) Program provides accurate information to physicians on the appropriate utilization of health care technology. DATTA evaluates the safety and effectiveness of drugs,

devices, and procedures by integrating the expert opinions of physician-consultants with systematic reviews of the scientific literature.

Prevention

Before turning to some of the specific actions that can be taken in moving to a reformed health care system that will address costs, I would like to express our appreciation for the recognition in the President's and other proposals of the importance of prevention health services. The benefits of such services are obvious and will allow the early detection of illness when treatment can be most efficient.

We believe, however, that prevention is more than just a series of covered benefits in a health insurance plan, such as annual physical examinations or immunizations. Prevention must also be thought of in far broader terms if we are to really be able to use this as a means to help hold the line on costs. We all know the benefits of certain lifestyle modifications such as the cessation of smoking, increases in exercise, a rational diet, and the avoidance of alcohol and other drug abuse. An additional area where we have a huge potential for the application of prevention is in addressing the epidemic of the 1990's: violence. We need to recognize that violence strains our health care system and adds cost to our health care bill. While these costs are not unique to America, it is unfortunate that the level of violence related costs are unique to America. As published in the Journal of the American Medical Association in 1988, hospital costs related to firearm injuries alone add an estimated \$429,000,000 to health care costs each year. Adding the cost of related services for ambulances, physicians, rehabilitation and long-term care costs, total medical expenditures for firearm injuries reaches an estimated \$1,000,000,000 annually. If anything, this estimate is

low with the recent surge of violence in our cities. Over 2 million people suffer from violent non-fatal injuries; this is on top of the estimated 150,000 deaths that are attributable to violence. In 1988, over $5,000,000,000 in direct health care expenditures were attributable to violent acts.

The AMA has a number of additional recommendations of actions for better controlling health care costs.

Health Insurance Market Reform

The AMA endorses the directions contained in the President's and other proposals to establish standard coverage, eliminate the application of pre-existing condition limits, and move towards true community rating. These changes, long advocated by the AMA, will make health care coverage far more accessible, more affordable, and ultimately less expensive.

Administrative Costs

If any aspect of the health care system lends itself to economy, it is the administrative costs in the system. The use of uniform claim forms, standardized and well understood utilization review procedures, and the move to uniform electronic billing formats and software certainly will reduce dollars spent on the processing of claims. It should be pointed out, however, that certain estimates of administrative costs (some have said 25% of total spending) are unreasonably high and savings in this range could not reasonably be expected to be achieved.

Cost Consciousness and Competition

This is one area where the private sector clearly has demonstrated results without government intervention. The marketplace can work to reduce the rate of increase in costs.

The rate of growth for health care expenditures has been reduced in areas of the country where insurers, physicians and providers of care have taken an active role in taking affirmative steps to restrain cost growth. Furthermore, physicians have a responsibility to discuss not only what care they are providing but also the cost of that care. AMA supports disclosure of price information to patients as a means of raising patient/consumer awareness, and with the existence of some patient responsibility, as called for in many of the reform plans including the President's, for some level of the cost of the care provided, it is reasonable to expect that costs will go down as part of the competitive environment. We have also long supported a cap on the tax free nature of health insurance benefits similar to the proposal in the President's plan. Such a cap can make the consumer a more cost effective shopper for the coverage that best meets their needs.

Liability Reform

The need for liability reform has been stated in many forums. As we will be testifying before this subcommittee on this specific issue the day after tomorrow, the current liability system is simply expensive and inefficient. For health system reform to be successful, we believe that it must include a strong liability reform element. The AMA supports reducing costs attributed to liability such as defensive medicine by tort system reforms. A cap on non-economic damages and a realistic cap on attorney contingent fees would go a long way toward improving the litigation climate.

Anti-Trust Protection

As health system reform moves forward, we strongly urge the inclusion of anti-trust modifications that will allow true peer review of fees and other matters. Under the current

Department of Justice/Federal Trade Commission interpretation, effective fee peer review is highly unlikely. Where a local medical society may actually operate such a program, participation must be voluntary for both the physician and the patient and the medical society's opinion is non-binding. The current FTC safe-harbor for this activity also requires that there be no public discussion of the propriety of physicians' fees. In this environment, there is no way that current law authorizes anything that is remotely close to effective fee review. In addition to amending the anti-trust laws to allow for physicians to be able to effectively negotiate with a regional alliance or other insurer, or payor for services, amendments are needed to allow the profession to effectively police itself. Patients should be able to rely upon the fact that their physician is a professional and that one of the responsibilities of a profession is to guard against abuse by the individuals involved. Finally, amendment of federal anti-trust laws is needed to allow groups of physicians to organize into efficient health care delivery networks that can improve the delivery of care and negotiate effectively with large insurance companies to assure that patient care needs are met.

CONCLUSION

Physicians and other health care professionals in the United States are able to provide our citizens with a breadth and quality of care that was not even imagined a few short years ago. The health care environment of 1993 is vastly different from that environment in 1983, and it is the patient who benefits. While we fully recognize the need to constrain the rate of growth for health care services, that restraint should not be at the expense of improved care and improved outcomes. For example, a decision that in effect slows the diffusion of new technology will result in that technology being inaccessible to many patients who could

potentially benefit. We do not question the need to incorporate cost considerations into the health care decision making. However, those decisions still must be made within the context of the individual patient.

The American Medical Association and physicians remain concerned that the direction some offer to control health care costs includes a cap on the rate of growth for health care spending. As contemplated in the President's plan, a regional alliance inflation factor that would cap insurance premiums would serve as the basis for controlling increases in health care spending. This factor would be based on the consumer price index plus changes in population and real per capita gross domestic product. Our concern is that the bottom line result would be price controls. Looking at the history of price controls and similar limitations, they have not been successful in controlling increases in spending and they inevitably lead to unintended negative side effects.

We believe that spending increases must be attacked using reform strategies that will address the causes for the increased spending rather than just the symptoms. The AMA supports better competition that will result from an enhanced insurance and health care market. As part of an improved market for the provision of health care, we believe that predictable spending should be used as a tool to heighten awareness of spending patterns and to set the focus for refinement of cost-containment mechanisms aimed at identified, unwarranted spending.

Mr. Chairman, thank you for the opportunity to testify. I will be pleased to respond to questions at the appropriate time.

Mr. WAXMAN. As I listened to the testimony of the four of you, it seems there is a significant difference of opinion on how we should control increases in health costs.

Mr. Dowling, you and Dr. Coleman both testified that, beyond whatever we may do to restructure the delivery system, we must have an enforceable limit on the growth in health spending.

Mr. King, you reject this approach, arguing that, to control spending through a rigid formula, is like putting on cruise control, taking one hand off the steering wheel, and hoping for the best.

Is it correct to assume that there is a major difference of opinion within the medical profession and the hospital industry?

Is it unfair to take from this that there is substantial support within both communities for the President's cost-containment proposals?

How do you all react to that?

Mr. COLEMAN. Mr. Waxman, as you said from my testimony and the testimony I sent through previously as you questioned the insurance people, the academy sees the caps as that backdrop Mr. Wyden spoke of.

We feel from our experience as family physicians, we have to be cost conscious because of our type of practice, that this can be accomplished in the physician community as well as in the hospitals.

But we have no objection to the budget caps. We do realize that we have to control costs. They are not going to stop me flat. We have to change the angle of that curve if we are going to get control and get access for everyone.

Mr. DOWLING. I think there is a difference of opinion but it may not be, in some respects, as far apart as you imagined.

We, too, believe that there needs to be some kind of budget or expenditure ceiling or limit. Our concern, however, is that it be an arbitrary formula-driven, top-down approach and not, therefore, have anything to do with the forces driving costs in the health care field.

In some years, frankly, that could be a cap that was too high and in some years it can be too low. We argue for drawing on an expert, independent body that could use information from the States and other experts to develop the annual budget cap or expenditure limit.

I would argue for starting with what it costs an efficient, effective delivery system to actually deliver the defined guaranteed uniform benefit package.

We put such a reform approach in place in Washington State. We have yet to see how it will work, of course. But the commission is responsible for establishing the maximum premium that health plans can charge for a defined benefit package.

But it will not be using an arbitrary formula for that. It will be beginning with what it cost our most efficient plans to do that and then consider other information about population trends, illness patterns, new technology, improvement, and productivity, et cetera.

Mr. WAXMAN. Mr. Schenken.

Mr. SCHENKEN. I don't think there is a big difference of opinion in terms of the goals of the people within the medical profession, but I think there is a substantial difference of opinion on the impact that some of these untried concepts are going to have.

I can only tell you, from my personal experience, having worked under global budgets, that once the global budget is established, then the incentives are actually there, only to increase the demand side, either from promises or expectations or whatever.

I worked in the State of Louisiana at the New Orleans Charity Hospital, the largest institution at the time. We ran out of money twice during our global budget periods.

Louisiana is a poor State and may not be comparable, but the arbitrary establishment of price controls and global budget, without dealing with all the things on the demand side, just constricts the problem, enforce it into the individual contacts between doctors and patients.

Medicine is not that precise. So if you look at all the history, look at Canada, look any place else, you have to look over at the demand side. And we think there is a lot of evidence out there that changes in the incentives, changes in the way the health care is financed, conduct of doctors, it goes on and on. There is lots of evidence that this will be a better way than putting a cap on the budget and just letting the demand side go crazy.

Mr. WAXMAN. Mr. King, do you want to respond?

Mr. KING. I think that the managed competition system in this country is going to take time and a great deal of restructuring at the local level at least in some markets.

Some of the things we described to you in the Portland area have taken place over a decade. To approach this Nation from an arbitrary CPI approach, from the top down, without building the infrastructure underneath and without understanding what reasonable capitative costs are at the local level, seems to be something we should be very careful about.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you.

It is an excellent panel.

Mr. King, it seems to me you have told the Oregon story and it is an important story that needs to be told. Let's say hypothetically, in the tri-county area around Portland—Multnomah, Clackamas, and Washington—where the population base is, what would happen, in your view, if we had a creature called the Colombia River Health Alliance and the structure the President is calling for in his bill?

This is for purposes of discussion, since we are in a market that is unique. I am interested in your assessments as to what would happen if we had the hypothetical Colombia River Alliance come in and start in a year.

Mr. KING. Assuming that we have universal coverage, which we don't have yet in Oregon, we would have a very positive step.

Second, we would also be concerned in Oregon that either the imposed rates or the goals that were set by this alliance on a—let's say on a global basis, that they be fair in relationship to other parts of the country, that we in Oregon have costs which are substantially lower than in some other parts of the country.

And it will be difficult if all alliances were treated equal in terms of future cost increases. We have made many of the investments in our market. We are now returning those investments in lower premium increases within Oregon in the last 2 or 3 years.

Other parts of the country are going to be making their investments in managed care infrastructure and will probably not enjoy some of the fruits of that for 3 to 5 years.

An arbitrary CPI-type, top-down, artificial caps set on a global basis without regional variation, it seems to me, would destroy much of the enthusiasm that we have for managed care in our market.

Mr. WYDEN. Let me take the answer that you gave, Mr. King, which is helpful, and use it to kind of touch on this point Mr. Dowling made about his concern about caps and, in particular, his idea of the top-down approach and it is much better to have something that would come in a more reflective way from the grassroots, from experience, and from mature markets and what we know is working.

The only problem—and we don't have to face it today, but we will have to face it when this legislation is processed—is in this so-called world of the Beltway. It is not the world where you all delivering health care to people but in this world of the Beltway you have to have a savings proposal scored.

You have to call up people at the Congressional Budget Office and the Office of Management and Budget and say, score this thing.

Basically, what has happened, they say, we can score this premium cap business but we cannot score all these other creatures even though we like the idea of it not being top down but more bottoms up.

My question is: If we come to an impasse on this issue, which makes more sense, do nothing because we don't yet have the data to go bottoms up, or do we want to run the gamut here and decide to go for it and say, let's take something with some kind of safety thing, some kind of backstop, even though it is more top down than you or I would like, in order to get some savings from universal coverage?

Mr. DOWLING. There is a temptation to say that is what you were elected to deal with.

I think one would have to take a look at the formula and make a judgment call at that particular point in time about how reasonable it looked based on whatever we believed or understand to be happening in the health care system.

On the other hand, I am not sure I agree with you that it would be as difficult or time consuming to put this in place.

The Clinton proposal calls for the establishment of health alliances. Presumably they will come on line fairly quickly. They have some major jobs to do. One is to develop the information. The second is one of the ways one finds out; what an efficient and effective delivery system can benefit the package; three, is to ask them.

One can quickly expedite the bidding process and discover what the more effective plans can do and begin to build that global budget up from that capitated kind of community up get from a bidding process, particularly as managed competition would have it, to the credit, I think, you structure the market in such a way that efficient, effective delivery systems want to come in order with a good bid so they can enroll more people, et cetera.

I am not sure it has to be quite as detailed and time consuming as you are suggesting.

Mr. SCHENKEN. May I make a short response?

Mr. WYDEN. Yes. When you are all done commenting, I want to make a request before my time is up because I think we are on to something.

Mr. SCHENKEN. You may well have put your finger on the problem with the scoring process when you are attempting to deal with the private sector for government expenditures.

Let me give you a very personal example. I run a big laboratory. I have 220 people work for me, about 400 insured lives. Four years ago health insurance became a very difficult cost of operation. As you know, laboratories are very competitive. We work on a very narrow margin. We changed the policy we have, the incentives. We did some reinsuring and some other things.

In the past 3½ years, we have stopped the rate of increase period and have achieved some substantial changes.

I really would not want to be forced into a regional alliance that I don't understand under those circumstances. I think that is one of the problems we are going to face in that there is a lot of private sector initiatives that are actually working.

Mr. WYDEN. I don't think the die is yet cast on the exact nature of the alliances, but I don't think much has changed on this issue in the last couple of years.

I talked to my staff a few minutes ago. I wrote an op-ed piece for the Washington Post a year and a half ago that called for a system that allowed first crack for the markets; but if and where the markets did not work, there would be some kind of backstop that would kick in.

I don't think the debate has changed all that much from that point. I think it would be helpful if you and your organization would be willing now to at least give us some ideas for the most palatable way in which you might put this backstop in because, you know, there are ways that will cause great damage to fairly mature markets like Portland.

There are ways, it seems to me, where we can do pretty much what Mr. Dowling has talked about, which is to allow for a lot of development. But this is only going to be possible if we get from people like yourselves, on the front lines, your thoughts on what this kind of backstop ought to look like and how it ought to be possible.

The light is on. That is a signal to end the speechifying. But I would be very interested in seeing your thoughts.

Thank you, Mr. Chairman.

Mr. WAXMAN. Clearly, Mr. Wyden is putting his finger on a difficult problem. This panel has done an excellent job. We are going to need your help to try to work our way through the difficulties we have with this whole idea of how to contain costs in a way that is consistent with good quality care and without doing harm to the competitive forces we would like to have operate in this area.

Thank you very much.

[Whereupon, at 2:40 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

HEALTH CARE REFORM

Impact on Medicare

THURSDAY, NOVEMBER 18, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Today's hearing will give the subcommittee an opportunity to examine the Medicare policies included in the President's health reform plan. The impact of these recommendations on Medicare beneficiaries and on health professionals and institutions that serve them is critically important.

Let me express at the outset my sincere regret for any inconvenience that may have been experienced by members of the subcommittee or our witnesses as a result of the postponement of this hearing last Monday. Representatives from the administration asked for this delay on Sunday giving us a very short time to notify all those involved.

The Medicare program currently provides health coverage for over 34 million elderly and disabled persons. For the most part, covered health services are available from physicians and hospitals chosen by beneficiaries, and while the program enjoys a broad base of support, there is certainly room for improvement. Current benefits do not include coverage for outpatient prescription drugs—a major expense for the elderly and disabled—and coverage for preventive and long-term care services needs to be expanded.

At the same time, we all recognize that the cost of Medicare continues to rise rapidly. Increases in excess of 10 percent a year have been the pattern in recent years. This growth has been difficult to sustain in a time of growing budget deficits and has required this subcommittee to face some very painful choices.

Just this past summer, we sent to the President a deficit reduction bill that cut Medicare expenditures about $56 billion over the next 5 years. These Medicare cuts in the absence of fundamental health reform have resulted in higher costs to employers, workers and beneficiaries as health providers have shifted the impact of these reductions by raising their prices to other purchasers.

The President recognizes this, that this cost shifting cannot continue. His reform plan brings health coverage to all Americans and does so in a way that seeks to distribute the costs of care fairly across all Americans.

However, the President's plan also calls for an additional $124 billion in Medicare savings over the next 5 years. While he intends to invest these savings in expanded Medicare coverage for prescription drugs and home and community-based care, I am disturbed by the magnitude of these cuts. I believe they are excessive and could adversely affect the quality and availability of services for beneficiaries.

There is no question that some reduction to the growth of Medicare can be realized as a result of universal coverage and stronger incentives for a more efficient delivery system, as provided in the President's plan. However, we should concentrate on those payment policies that can be adjusted because universal coverage is in place and we must take great care to coordinate these changes with the schedule for expanded coverage. Those hospitals and physicians who are serving unsponsored patients now must not be put at risk of failure by excessive or ill-timed Medicare cuts.

I would also be remiss if I did not express my concerns about the opportunity for States to take over Medicare under the waiver authority provided in the President's bill. Given some of the experience we have had in Medicaid, I believe we need to carefully examine the terms and conditions of such waivers. Certainly Medicare beneficiaries must have the same protections and opportunities for choice that they now enjoy.

Again, I want to thank our witnesses for accommodating our scheduling changes. I look forward to today's testimony and the opportunity to learn more about how we can strengthen the Medicare program and coordinate it with our broader reform goals.

Before calling on our first witness, I want to recognize my distinguished colleague, the ranking member of our subcommittee, Mr. Bliley, for any opening statement he may have.

Mr. BLILEY. Thank you, Mr. Chairman.

I would like to join you in welcoming our witnesses to today's hearing. This is a particularly important hearing because we will be hearing from two very important groups that will be greatly affected by health care reform: The elderly and the community of doctors and hospitals that provide that care.

Both of these groups are particularly important to the discussion because a major portion of the Clinton health care reform package is supposed to be financed by reductions in the Medicare program; $124 billion over 5 years, following on the heels of the $56 billion in cuts made in OBRA 1993.

First, let me say that it is very unfortunate that we are more than halfway through our hearing schedule on the administration's health care proposal and we still do not have, one, an introduced bill and, two, any response to our requests for their working papers detailing the assumptions, estimates, and quantitative analysis of the plan's financing, cost containment and impact on employment.

Since I am not aware of one independent health care expert or economist who has found the administration's financing and cost containment proposal credible, it is critical that this documentation

be made public so that Congress and the public can determine the validity of the analysis.

I would like to remind my colleagues that the first question I asked Mrs. Clinton at our September 28 hearing was her willingness to make available to the committee the task force quantitative work product. Let me quote Mrs. Clinton's response: "We will be happy to share with you all of the data that you requested, all of our calculations, our economic models, et cetera." Unquote.

Well, it is now more than 7 weeks later and we are still waiting. I have written to Mrs. Clinton and have received no response. When Secretary Shalala testified, she assured me that they would be made available at the same time the bill was sent up. When Judy Feder testified, she assured the subcommittee they would be made available immediately. I am still waiting.

I am a very patient man but I am beginning to feel some frustration about this matter. At Secretary Shalala's recent appearance before the Senate Finance Committee, she assured the committee there are no rosy scenarios here. She said, there are no magic asterisks; these are conservative numbers that we believe will stand the test of public scrutiny.

To state the obvious, if the data behind the numbers are never made public, the test of public scrutiny will never take place.

In a recent editorial by Meg Greenfield in Newsweek detailing the history of this country's dismal record on estimating the cost of new programs, she concluded, above all, believe that all numbers are provisional and that anything that looks easy is almost certainly fake.

I am becoming convinced that Ms. Greenfield has provided us with an accurate description of the financing in the Clinton health care plan.

Let me make some brief comments concerning the witnesses today. The impact on Medicare beneficiaries and the quality of care they will receive as a result of the administration's proposal deserves careful scrutiny. The impact of the proposed Medicare cuts totaling $124 billion over 5 years must be carefully evaluated.

Is there so much waste in the current program that these cuts will not affect the quality of care? Interestingly, we have asked this question of several administration witnesses. At this point, I have not received a satisfactory answer.

The fullest answer was given by Mrs. Clinton. She said that Dr. C. Everett Koop had told her there were $200 billion of wasteful and unnecessary costs in the U.S. health care system. Two hundred billion dollars would represent approximately 20 percent of all national health care expenditures.

When Secretary Shalala testified before us, I asked her to document some of the $200 billion of unnecessary costs in the system. She was able to document only a small fraction, $1.5 million, to be exact. Maybe some of our witnesses today can document the $200 billion figure, and, more importantly, show us how we are going to become the slowest growing health care system in the Western world without rationing health care.

Now, let us turn to the providers. Under the Clinton plan, physicians and hospitals will face a new bewildering combination of Medicare and Medicaid cuts, global budgets and price controls, and

a new level of intrusive control and micromanagement by a national board and dozens of advisory councils, alliances and State boards which will make health care the most regulated sector of the entire economy. If health care has to be rationed under the Clinton price controls, it will be physicians who have to make those difficult decisions.

Finally, we must ask questions about the future of the Medicare system. From my reading of this bill, its future seems unclear because under both the single payer option and regional alliances, States can force either all or certain classes of their Medicare beneficiaries into the alliance system. And when States or their alliances opt out of Medicare, Federal payments will be capped at essentially the CPI level. The individual Medicare beneficiary will not have a choice.

Simply put, States or alliances will have the power to terminate Federal benefits for the elderly, disabled and ESRD patients and replace this efficient and popular program with an untested, arbitrarily capped program with no track record.

I look forward to the testimony of our witnesses and their views on these important questions. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Bliley.

Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman.

I want to commend you, as Congress' champion of Medicare for these many years, on calling this hearing. The fact of the matter is, and this is something I have been familiar with since my days as codirector of the Grey Panthers home in Oregon, is that Medicare is a throbbing, miserable migraine for millions of senior citizens in our country.

I think every member on this dais can identify with what I am saying because we all have caseworkers in our local district offices that spend a good chunk of their day just trying to wade through some of this incomprehensible mound of paperwork that the Medicare program generates. The fact of the matter is that kind of time really ought to be allocated as additional administrative cost to the Medicare program simply stemming from some of the inefficiencies.

One of the things I think members also ought to know, as we learned this summer, is that many of these Medicare carriers are running high-tech sweat shops where harried workers, with very often no medical training whatsoever, are required to process and make judgments about medical necessity on as many as 400 claims a day. That is one every 72 seconds, 8 hours a day. So I don't think it is any surprise that that is why our caseworkers then have to come in and clean up some of the Medicare mess that the administrative system has created.

Finally, Mr. Chairman, a word about cost. The fact is that millions of our senior citizens are now spending more out-of-pocket on health care than they did when Medicare began in 1965. In fact, according to the Agency for Health Care Policy and Research, seniors with Medicare coverage alone have out-of-pocket health costs so high that only the flat-out uninsured pay more out-of-pocket in America. So it is in this context that we have to evaluate the huge package of additional spending savings in Medicare that is being proposed by the administration.

The fact is, I think we need to spend some dollars to try to improve some of the inefficiencies that we saw this summer, and I, for one, am very skeptical that you can wring out more than $120 billion in savings in Medicare simply by going after inefficiencies. But I also want to note, Mr. Vladeck is a good man. We have enjoyed working with him, and if anybody can figure out how to make a case for this, he is the one who can do it, and we welcome him and look forward to his views this morning.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman.

Welcome back. We have the opportunity today to further discuss the President's plan with respect to Medicare under the Health Security Act, and I just got your numbers and I have not had a chance to digest them, but I am glad we finally got some sparce details on this issue. We have had the summaries and this will give us something to chew on.

I know there will be some in the administration who will claim that the savings generated in Medicare should be left in the Health Security Act and should not be addressed through any deficit reduction rescission package such as the Penny-Kasich amendment that will appear on the Floor this week. I would like to take a minute to differ with this ridiculous argument.

This administration claims that it would like to see a reduction in Federal spending and then when one is offered, they reject it because they claim the savings need to be spent on something else. This is essentially what your Medicare proposal does with $124 billion worth of "savings" over 5 years and $131 billion worth of additional spending.

But I want to make it clear at the outset that given the fact that the President's proposal—and if anyone would like to examine that, I have a chart given us 2 weeks ago by Ken Thorpe—in which the President's proposed overall plan projects $58 billion worth of deficit reduction over 5 years, and in addition to that, has a $40 billion cushion built into it. So that, in effect, there are in excess of $100 billion worth of funds in excess of those projected to be needed to meet all the spending proposals included in the President's plan.

The administration argues that we should not take some $37 billion worth of Medicare savings as a part of this rescission package, even though they are essentially the same savings that the President, I think, will propose now that we are beginning to get the detail. They are savings that have been discussed in the Budget Committee back to the time when Mr. Panetta was chairman of the committee. We looked at these things in detail and I think they found their way into the administration's proposal.

But those $35 billion worth of savings could be initiated now, maybe 12 months in advance of this health care plan, if and when it is adopted, and they don't take away any savings, they simply move them forward. The savings are still there for the administration to use on other programs. In fact, the administration by their own projections, have $100 billion over 5 years in excess of what they need to do everything.

So there is really no argument, in my opinion, to defer action on this. It simply moves the debate forward and does so in a construc-

tive manner. So I hope that we will have a chance to address this along with other matters a little bit further as we listen to your testimony.

I yield back the balance of my time. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan. Mr. Brown.

Mr. BROWN. No, Mr. Chairman.

Mr. WAXMAN. Mr. Cooper, opening statement?

Mr. COOPER. No opening statement, Mr. Chairman.

Mr. WAXMAN. Mr. Greenwood.

Mr. GREENWOOD. No, thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Moorhead.

Mr. MOORHEAD. Thank you, Mr. Chairman, and I wish to welcome the witnesses this morning. We look forward to the hearing, and I wish to associate myself with the remarks of the gentleman from Richmond who I think nailed the problems down pretty firmly.

I am most concerned about the huge cuts in Medicare and Medicaid, which I don't believe can be made without drastically affecting the services to our senior citizens. And if their services are gradually moved into other programs, the special care they have been receiving may very well be lost in the shuffle.

I think we have a lot of work to do on this whole plan before it can be enacted into law. It is unrealistic to think that the tremendous changes that are being planned can be made on $90 billion of new taxes. You cannot just cut the amount of money available and expect the health services to provide the quality of care that Americans are used to.

We can make great savings by cutting down administration costs and unnecessary forms that have to be filled out. And if we have the courage to work against malpractice and those programs, it is obvious that we can make cuts there in defensive medicine and otherwise. But this is a very serious type of change that we are considering and we have to be sure that we keep the same quality of care not only to the majority of citizens in our country but also to our senior citizens that depend upon it the most.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Moorhead. Mr. Klug.

Mr. KLUG. No opening statement.

Mr. WAXMAN. Well, once again, I am pleased to welcome back to the subcommittee Bruce Vladeck. Mr. Vladeck is the administrator of the Health Care Financing Administration and is responsible for managing the $156 billion Medicare program.

Mr. Vladeck has a long and distinguished career as a health policy analyst and manager at both the Federal and State level. He is widely regarded for his thoughtful contribution to the debate on many health policy issues.

Mr. Vladeck, we are looking forward to your testimony. Without objection, your full statement will be made in the record and we would like to ask you to proceed with your oral presentation.

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you, very much, Mr. Chairman. I appreciate those kind words, and I assume by reference to the full state-

ment you include the table appended to it, and I am really pleased to be able to submit that to the subcommittee this morning.

Mr. WAXMAN. We are pleased to receive it.

Mr. VLADECK. I am very pleased to be back with you again as part of our continuing journey in the exciting and vitally important process of health reform.

Before I begin very briefly summarizing the remarks I submitted, Mr. Chairman, if I may, I would just like to comment very briefly on the relationship between the Medicare spending reductions we are proposing as part of the President's health care reform proposal and the Penny-Kasich deficit reduction plan.

We do not believe that that plan represents good economic policy or good health policy. We believe that over time deficit reduction hinges quite critically on our capacity to make significant structural long-term change in the rate of growth of health care costs in both the public and private sectors in our economy, which these short-term rather improvisational measures we do not believe would.

As I will discuss, our proposals for reductions in the rate of growth in Medicare increases are part of a comprehensive package of reforms that also includes slowing the rate of growth of private sector health care spending and the addition of significant new benefits in the Medicare program for senior citizens and other disabled persons for long-term care.

We think there is a logical interconnection among those pieces that cannot be picked apart effectively one piece or another without undermining the entire structure of health care reform and, therefore, the issue of our concerns with this particular set of proposals is more than an issue of just where we count the money in some sort of budgetary accounting, it really has to do with the underlying philosophy and approach to a rational comprehensive policy towards the health care system. And I would be happy in the course of this morning's session to respond to any particular comments or questions that members might have relative to that issue.

I would like to begin, however, by spending a little bit of time talking about the relationship between the Health Care Security Act, the Health Security Act and Medicare beneficiaries.

When I appeared before you 2 weeks ago, I emphasized how committed this administration is to maintaining the highest possible quality of care and the most reliable coverage for the elderly and other Medicare beneficiaries, and I am pleased to begin this morning by repeating that message.

We have no intention of putting Medicare beneficiaries at risk. The reforms we are proposing are in the framework of a thorough reorganization of the health care system in which we believe everyone, including Medicare beneficiaries, will benefit.

Under the President's proposal, the Medicare program will continue to offer health security to America's elderly and disabled citizens more effectively and more comprehensively, and we hope with more choices, than they have ever had before.

Beneficiaries who are employed or who are the spouse or dependent of someone who is employed will receive their health care coverage primarily through an employment-based relationship, as they do now, but under health care reform through the regional health

alliances. These beneficiaries will be able to choose from among all the plans in their alliances and will be charged the same premiums as everyone else.

As we do now, we will automatically fill in cost sharing as the secondary payer for part B services. If beneficiaries elect to pay the part B premium, we will also provide secondary coverage for those services that are covered under part B.

Once the beneficiary is enrolled because of an employment relationship in an alliance, the beneficiary will remain in the alliance for the balance of the year, even if the employment ends. In that case, Medicare will pay the employer's share of the premium.

Individuals covered under an alliance plan who become eligible for Medicare will be permitted to remain in the alliance if they choose and if the plan in which they are enrolled has a risk contract with Medicare. To the greatest possible extent, we are trying to permit people to maintain continuity in care arrangements and provider relationships when they retire or otherwise convert from some other status to Medicare coverage.

Medicare, under those circumstances, will pay the same amount it would have paid had the beneficiary been enrolled in a Medicare risk plan and with the beneficiary paying the difference between the plan's premium and our payment, as is generally the case now.

Medicare-eligible individuals who choose to remain in an alliance plan may opt back into the regular Medicare program at any point on an annual basis in the future and remain there for the rest of their lives.

Within the Medicare program itself, we hope there will be very much expanded opportunities for beneficiaries to participate in managed care and that new laws will make medigap policies more acceptable. The President's proposal requires medigap insurers to accept all Medicare beneficiaries regardless of age or health at the same premium. We will continue to permit medigap insurers to exclude preexisting conditions, but only for the first 6 months of the first new policy.

To keep Medicare beneficiaries informed of the full array of options available to them, Medicare will have an open enrollment period giving beneficiaries the opportunity to switch to new managed care plans or medigap policies. During this period, beneficiaries will be provided with comparison information so they can make informed choices. This open enrollment will be conducted by a third party to prevent managed care plans and medigap insurers from marketing selectively to healthier, low-lower risk individuals.

In addition to expanded options for health care delivery, the elderly and disabled will have access under the Health Security Act to two new benefits that will help with health care needs that are becoming more and more unaffordable and increasingly the source of catastrophic expenses for beneficiaries.

Many elderly and disabled Americans enter nursing homes and other institutions when they would prefer to remain at home. And families often exhaust their savings trying to provide for disabled relatives.

Our plan will provide greater security for those in need of long-term care and their families by easing this financial burden through a long-term care benefit. This is not a part of the Medicare

program but rather a joint Federal-State grant and aid program. Over time, this benefit will make more home and community-based services available to individuals regardless of income without any means testing who are sufficiently disabled to qualify.

In addition, the Health Security Act will improve the private long-term care insurance market by establishing Federal standards which will be implemented and enforced by the States under plans approved by the Secretary. The cost to individuals of long-term care insurance and any amounts paid by them for benefits of long-term care will be excluded from taxable income.

Similarly, disabled individuals who are working will be eligible for a tax credit of up to the lesser of $7,500 in personal assistance expenses or half of the taxpayers' earned income as a way of supporting those disabled persons who wish to remain in the work force on a part or full-time basis.

We are particularly excited about the new Medicare prescription drug benefit. I understand that may be the subject of a separate hearing and I will refer to it only very briefly this morning. But it is a means of filling what I think is in many ways the largest gap in the current coverage arrangements of the Medicare program.

It is a benefit that will provide significant financial protection for Medicare beneficiaries, at the same time, if the benefit is developed and implemented as we intend, in conjunction with concurrent utilization review with profiling and with some of the other technologies and techniques available to us in terms of quality assurance in the dispensing of prescription drugs, we believe this will have a major positive qualitative impact on the services available to Medicare beneficiaries and reduce the very significant incidence of overmedication or mismedication and illness, et cetera, associated with that in the Medicare population.

In the context of the broader health security plan and the bringing down under that plan of private sector costs, we believe we can achieve Medicare savings without shifting those costs to the private sector or endangering beneficiaries' access to services.

The President's plan, as you well know, as virtually every other Democratic and Republican health care plan that has been proposed or introduced, recognizes that we can save money and must save money by lowering the rate of growth in Medicare and Medicaid.

Our bill has identified $124.4 billion in specific savings in the program to be redirected in the interest of the health of all Americans and in support of economic growth for the economy as a whole.

I should point out that this amount, this $124.4 billion, is roughly comparable to the savings proposed in the Senate Republican plan and less than the savings called for by some of the single payer proposals.

It seems like a very large amount of money, but we must remember that those are savings relative to a baseline of $1.2 trillion in projected Medicare spending in the period 1995 to the year 2000. What is more, and perhaps even more relevant and more important, is that the savings we are proposing reduces the rates of growth in Medicare outlays during the period 1996 through the

year 2000 from triple the inflation rate projected for the economy as a whole to merely double the inflation rates of the economy as a whole. But Medicare would still be growing, after these cuts, twice as fast as the average of the economy.

Lowering the rate of growth in Medicare program expenditures is, in the long term as well as in the medium term, perhaps the most important thing we can do for beneficiaries. In the short term, as some of our numbers suggest, lower expenditures mean that beneficiaries pay less out-of-pocket in the form of part B premiums, which we have tied to a portion of the costs of the program and in coinsurance and deductibles.

In the long term, it means that future Medicare beneficiaries can look forward to a stronger, more financially sound, more actuarially sound Medicare program because reducing costs in the health care sector as a whole and in Medicare outlays serves to improve the long-term integrity of the trust funds.

In putting together these savings, it was our intention and our goal to be as sensitive as possible to minimize the effect on beneficiaries. Although there are net contributions by beneficiaries in this package, the net amount is reduced substantially by the slowing of the rate of growth in the part B premiums and by the elimination of balanced billing making Medicare similar to other payers under the Health Security Act and saving beneficiaries' out-of-pocket expenses at the same time.

Those two proposals have the effect of lowering part B premiums to the extent of perhaps $10 billion over the life of this budget window.

We have 28 line-item proposals to achieve savings in the Medicare program. Many of them, accounting for about a quarter of the savings, are extensions of existing authorities incorporated in recent reconciliation legislation, such as the Medicare secondary payer provisions or the reduction in the hospital update factor.

Another roughly quarter of the total savings we are providing result from eliminating or reducing provider payments that were originally intended to ease the financial pressures created by uncompensated care and which we believe are rendered essentially redundant by universal coverage. Thus, payments to hospitals for indirect medical education and disproportionate share adjustments will be reduced, not eliminated, with the elimination of uninsured people and of large—pardon me—and the almost complete elimination of uncompensated care.

We have proposed $60.4 billion in part A savings. Roughly half of the total package of these include reducing the update for PPS hospitals in the years after 1996; reducing the indirect medical education adjustment; reducing the disproportionate share program; further adjusting, I think largely to reflect recent cost data as much as to achieve savings, prospective payments for hospitals' capital.

On the part B side, we are proposing to modify the Medicare VPS volume/intensity factor more closely to tie growth and physician spending to growth in the economy. We are proposing to establish cumulative MPVS rates of increase to ensure more predictability and control over expenditures rather than some of the fluctuation or oscillation we have been seeing.

We are proposing a very limited increase in the premiums for Medicare beneficiaries—solo, single individuals, with annual incomes over $90,000 a year, couples with modified adjusted gross incomes in excess of $115,000 a year—to pay a premium up to 75 percent of program costs as a way of making some relatively modest additional contribution to the insurance they are receiving; reestablishing 20 percent coinsurance on part B laboratory services and making some corrections to keep the part B premium at the 25 percent target throughout this period.

There is also about $17 billion in savings of programs that fall both under parts A and B establishing copayments for home health visits, except for those that occur within 30 days of a hospital inpatient discharge; expanding our limited demonstrations and centers of excellence for Medicare services for cataract and coronary artery bypass surgery; changing or extending for existing Medicare secondary payer practices, and making some relatively modest adjustments in our payment methodology for HMO's.

Finally, we have one proposal that will produce slightly over $7 billion in new revenues. This would require all State and local government employees who are now exempt from doing so to pay the Medicare hospital insurance tax from which the overwhelming portions are likely to benefit when they reach retirement age.

In summary, Mr. Chairman, the President's health security plan includes important proposals that reinforce the program while at the same time reducing its rate of growth. We believe these changes in the Medicare program are attainable and necessary for successful reform of the health care system as a whole.

To repeat something I said the last time I had the pleasure of appearing before you, we believe that we do have the resources to meet the health care needs of all our citizens if we spend our dollars more wisely. With everyone's willingness to participate, we can afford universal coverage without compromising quality or limiting the availability of necessary health services for the elderly population or any other population in this country.

I look forward to working with you in the months ahead to forge a consensus on health care reform that promotes the improved health status of all our citizens and strengthens our national productivity.

Thank you very much.

Mr. WAXMAN. Thank you very much, Mr. Vladeck.

[Testimony resumes on p. 362.]

[The prepared statement of Mr. Vladeck follows:]

79-704 O – 94 – 12

STATEMENT OF

BRUCE C. VLADECK

ADMINISTRATOR

THE HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to appear before you again today. I view each of these hearings as another opportunity to press forward in the reform of the country's health care system. It's an exciting prospect that we are finally advancing towards providing health care security to every American citizen.

Before we begin this morning, Mr. Chairman, I would like to briefly comment on an amendment that may come up for vote in the House during the next few days: the Penny-Kasich deficit reduction plan. The Administration believes that this plan does not represent good economic policy and might even hurt the prospects for deficit reduction. One of the specific objections the Administration has about this amendment is that it would hurt the economy by significantly complicating reform of the health care system. The Penny-Kasich amendment would claim Medicare savings that are included in the financing of the President's plan. In fact, $35 billion of the $103 billion in savings in the Penny-Kasich package are similar or identical to our Medicare savings proposals which I will discuss today. Taking away critical elements of the health care reform bill at this time will hinder, not help, ultimate deficit control. These essential funding elements of the health bill must be reserved for health reform if the goals of health cost control and universal coverage are to be achieved.

Today I'm here to discuss Medicare beneficiaries and how they will fare under the Health Security Act. When I appeared before you two weeks ago to discuss the State role in the President's plan, I emphasized that we are very committed to continuing high quality and reliable coverage for the elderly.

That message bears repeating. This Administration has no intention of putting Medicare beneficiaries at risk. The Medicare reforms we are proposing will be within the framework of a thorough reorganization of the health care system in which everyone stands to gain.

This morning I will talk about how the Medicare program will be strengthened and enhanced by new benefits and expanded choices for health care delivery. And I will also discuss our savings proposals for the Medicare program which, in large part, will be facilitated by the more efficient health care environment created by the Health Security Act.

Options for Medicare Beneficiaries

Under the President's plan, the Medicare program will continue to offer health security to America's elderly and disabled citizens — only now with more health care options than they've ever had before.

Beneficiaries who are employed, or who are the spouse or the dependent of someone who is employed, will receive their health care coverage through regional health care alliances. These beneficiaries will be able to choose from among all the

plans in their alliances and will be charged the same premium as everyone else. Medicare will automatically fill in plan cost sharing as the secondary payer for Part A services. Beneficiaries may also obtain secondary coverage for Part B services if they pay the Part B premium. Once in the alliance, the beneficiary will be there for the entire year even if the tie to employment ends. In that case, Medicare will pay the employer share of the premium.

Individuals covered under an alliance who become eligible for Medicare will be permitted to remain in the alliance if they choose — if the plan they are enrolled in has a risk contract with Medicare. The Medicare program will pay the plan the same amount it would have paid if the beneficiary had enrolled in a Medicare risk plan. The beneficiary will make up the difference between the plan premium and the Medicare payment. Medicare eligible individuals in the alliance may later choose to return to Medicare and remain enrolled there.

For beneficiaries who choose Medicare, there will be expanded opportunities to participate in managed care and new laws making Medigap policies more accessible. The President's plan will require Medigap insurers to accept all Medicare beneficiaries, regardless of age or health, at the same premium. Medigap insurers will, however, continue to be permitted to exclude preexisting conditions, but only for the first six months of the first new policy.

To keep Medicare beneficiaries informed of the full array of managed care and Medigap options available to them, Medicare will hold an annual open enrollment giving beneficiaries the opportunity to switch to new plans or policies. During this enrollment period, beneficiaries will be provided with comparison information on every available managed care plan and Medigap policy so they can make informed choices. This open enrollment will be conducted by a third party to prevent managed care plans and Medigap insurers from marketing selectively to healthier, low-risk individuals.

As I explained during my last hearing, States can apply to the Secretary for approval to integrate Medicare beneficiaries into their regional alliance or single-payer systems. We will approve such requests only if the State is capable of meeting certain strong guarantees. First, neither the beneficiaries nor the government will be financially worse off. Second, quality will be equal or better. And finally, at least one fee-for-service plan must be available to the beneficiaries at no greater out-of-pocket cost than they would pay under Medicare.

New Benefits

In addition to expanded options for health care delivery, the elderly and disabled will have access to two new benefits that will help them with health care needs that are becoming more and more unaffordable — and even catastrophic for some.

Many elderly and disabled Americans enter nursing homes and other institutions

when they would prefer to remain at home. And families often exhaust their savings trying to provide for disabled relatives. Our plan will provide greater security for those in need of long-term care and their families by easing this financial burden through a new **long-term care** benefit. This is not a benefit sponsored by Medicare, but rather jointly sponsored by the State and Federal governments. Over time, this benefit will make available more home and community-based services to individuals, regardless of income, who are sufficiently disabled to qualify.

In addition, the Health Security Act will improve private long-term care insurance by establishing federal standards which will be implemented and enforced under plans developed by States and approved by the Secretary. And the cost to individuals of long-term care insurance and any amounts paid by them for long-term care services under an insurance policy will be excluded from taxable income. Similarly, disabled individuals who are working will be eligible for a tax credit of up to the lesser of $7,500 in personal assistance expenses or half of the taxpayers earned income.

A new Medicare prescription drug benefit will have a major impact on the quality of life of the elderly. Right now, drug costs force some older Americans to choose between food and medicine. Making prescription drugs financially accessible to the elderly will help eliminate illnesses and unneeded hospital stays.

As in the comprehensive benefit package, the Medicare drug benefit will cover all drugs, biological products and insulin approved by the Food and Drug Administration. Since the drug benefit will be incorporated into Part B, Medicare beneficiaries will see an increase in their Part B premium. They will also have to meet an annual drug deductible of $250. As with other Part B benefits, beneficiaries will be responsible for 20 percent coinsurance on all prescription drugs. Unlike other part B services, however, there will be a $1,000 limit on beneficiary out-of-pocket spending. Low-income Medicaid and Qualified Medicare Beneficiaries will continue to have their cost-sharing paid by Medicaid.

The Medicare prescription drug program will benefit from the expertise and success we have already achieved in the current Medicaid drug program. Drug manufacturers will have to sign rebate agreements with the Secretary, similar to those they sign now under the Medicaid program. An additional rebate will be levied for drugs whose prices increase faster than the rate of inflation. For new drugs, the Secretary will have authority to negotiate with manufacturers for a discounted Medicare price. Medicare will cover any new drugs for which the Secretary and manufacturers can agree on a satisfactory price.

I should point out that we adopted this approach of rebates, discounts and negotiated prices because the pharmaceutical industry was adamantly opposed to Medicare's use of private sector strategies to hold down prescription drug costs. In particular, the industry opposed Medicare's use of negotiated formularies which private plans will use to receive prescription discounts. Today, private hospitals and HMOs negotiate with manufacturers for price discounts in return for covering that manufacturer's drugs on their formulary. To avoid distorting the outcome of other

market negotiations, we agreed to adopt the approach we did. Given the variety of approaches, we will be pleased to continue discussions with this subcommittee and the industry on the most appropriate strategies for protecting the Medicare program and the taxpayer while assuring access to needed medications for the elderly and the disabled.

We have a good track record from experience in the Medicaid program with drug manufacturers and States in developing working relationships, establishing new data and reporting systems, and implementing billing and processing systems. The large volume of drug claims that will result from this benefit will be best handled by electronic on-line systems in pharmacies for drug utilization review and claims payment purposes. While complex, an electronic drug claims processing system is much more achievable now than 5 years ago, when we were working on the Medicare catastrophic drug benefit. Currently, Medicare leads the industry in electronic claims processing. The system could facilitate the establishment of a drug utilization review program to identify duplicate prescriptions or potential adverse reactions, if analysis suggests this is our appropriate choice.

Savings in Medicare

In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs or endangering beneficiaries' access to services. The President's plan — and virtually every Democratic and Republican health care plan that has been proposed — recognizes that we can save money by lowering the rate of growth in Medicare and Medicaid. Our bill identifies $124.4 billion in specific, scorable, line-by-line savings in the Medicare program. That's $124.4 billion dollars to redirect in the interest of the health of all Americans and in the interest of the Nation's economy.

This amount is comparable to the savings proposed by the Senate Republican plan, and less than the savings called for by some single-payer proposals. And while the amount of our savings may seem high today, we must keep in mind they will be taken from a future base of $1.2 trillion in projected Medicare spending over the years 1995 to 2000. What's more, the $124.4 billion will only reduce the growth in Medicare spending from triple the inflation rate to double.

Lowering the rate of growth in Medicare program expenditures is perhaps the most important thing we can do for beneficiaries. Lower expenditures over time mean that beneficiaries pay less out-of-pocket in the form of coinsurance and deductibles. It also means that future Medicare beneficiaries can look forward to a stronger, more financially sound, Medicare program because reducing costs in both sectors of the economy will serve to improve the long-term integrity of the Medicare trust funds.

It was our intention to be as sensitive as possible when developing our savings proposals in the Medicare program — especially where beneficiaries are concerned. The Medicare savings affecting beneficiaries will be a result of increasing premiums

for beneficiaries with incomes in excess of $90,000 for individuals and $115,000 for couples, continuing the current policy on premium levels, and from charging cost sharing for Medicare home health and laboratory services which, unlike most Medicare services, are now provided without cost sharing.

However, beneficiaries will no longer be subject to balance billing, making Medicare more consistent with alliance plans. These saving proposals will result in lower part B premiums, saving beneficiaries almost $10 billion over 6 years.

The Administration has offered 28 proposals to improve the operations of the Medicare program. Many of these proposals are extensions of expiring authorities such as the Medicare secondary payer provisions and the reduction in the hospital market basket.
Another significant portion of the savings from these proposals are largely a result of eliminating or reducing payments to providers that were originally intended to ease the financial pressures created by uncompensated care. Payments to hospitals for indirect medical education and disproportionate share adjustments are examples of such payments. With universal coverage, virtually all care will be compensated.

<u>Medicare Part A</u>

The Health Security Act includes the following proposals affecting Medicare Part A services.

- **Reduce the update for PPS hospitals** by a further 1.5 percentage points in fiscal year 1997 (for a total of 2.0) and maintain this 2.0 percentage point reduction in fiscal years 1998 through 2000. We are projecting market baskets of 5 percent a year in fiscal years 1996 through 2000. This proposal will give hospitals updates of 3 percent a year (and more when considering case mix increase, which is in the range of 2 percent a year). This proposal will save $18.16 billion over six years.

- **Reduce the indirect medical education adjustment factor** from 7.7 percent to 3.0 percent in fiscal year 1996 and increase that amount by increases in the alliance premiums thereafter. Studies over the years have shown that the current level of the IME adjustment is not justified and that it overcompensates teaching hospitals for their indirect teaching costs. At this level, Medicare will contribute about one-half of the payments to the Academic Health Center pool established by the Health Security Act. Six year savings for this proposal will be $17.84 billion.

- **Reduce Medicare hospital capital payments.** This proposal combines three inpatient capital adjustments. The first adjustment reduces rates to reflect more accurate base year data and cost projections. These reductions are based on more recent data on both the cost of capital and in the rate of increase in capital costs per discharge. The second proposal reduces the update factor to account for excess capital spending prior to implementing the capital prospective payment

system. Third, we will also initiate a 15 percent reduction in payments for capital in non-PPS hospitals. Six year savings will be $10.325 billion.

- **Replace the current disproportionate share hospital program with a new program** as States enter into the system. The new program will assist hospitals serving the largest share of low-income patients. Hospitals that have a disproportionate share of low-income patients will receive an additional payment from Medicare. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income patients. Six year savings will be $14.63 billion.

- **Eliminate prospective payments system exemptions for new long-term care hospitals**. Long-term care hospitals, which have an average length of stay of over 25 days, are currently exempt from the PPS system, receiving cost-based reimbursement from Medicare, subject to TEFRA limits. This proposal will establish a moratorium on new long-term care hospitals receiving exemptions from the Medicare prospective payment system. Six year savings for this proposal will be $530 million.

- **Assure that OBRA 93 skilled nursing facility savings are retained.** OBRA 93 established a two-year freeze on updates to the SNF limits. However a "catch-up" would occur when the SNF freeze expires on October 1, 1995 -- limiting the savings to two years. This proposal will eliminate the inflation "catch-up", and provide permanent savings by recalculating the percent of the mean that would produce the same amount of savings as if the freeze were continued. This proposal will result in a 6 year savings of $830 million.

Medicare Part B

Proposals to reduce the growth in Part B spending in the President's plan include the following:

- **Modify Medicare volume performance standard volume/intensity factor.** Beginning with the fiscal year 1995 MVPS, replace the current five-year volume/intensity factor and the performance standard factor with the five-year growth in real gross domestic product GDP per capita for surgery and other physician services, and with real GDP per capita plus 1.5 percentage points for primary care services. The current method of setting the MVPS results in excessively high targets and inappropriate updates. Using real GDP per capita to set the MVPS ties growth in physician services to real growth in the economy. This proposal is consistent with a recommendation of the Physician Payment Review Commission. The six year savings for this proposal will be $6.1 billion. Beneficiaries will experience savings of about 25 percent of this amount through lower cost-sharing liabilities.

- **Establish cumulative MVPS rates of increase** for each of the three separate categories of service: primary care, surgery, and all other services. Currently, the

MVPS for each year is based on the prior year's actual rate of growth in outlays without regard to the prior year's target rate of growth in outlays. This proposal will link the MVPS for each category of service to a base year (fiscal year 1995). This approach assures more predictability and control over expenditures for both physicians and the Federal government. This proposal will save $5.815 billion over six years. Beneficiaries will experience savings of about 25 percent of this amount through lower cost-sharing liabilities.

- **Reduce the 1995 non-primary care physician conversion factor by 3 percent.** This reflects our belief that the 1994 update will be excessive because the default formula for computing the MVPS factored in unreasonably high volume and intensity levels. Had the fiscal year 1992 MVPS formula provided for volume and intensity allowances consistent with projections in the Trustees Reports or based on GDP growth as we are now recommending, the resultant MVPS and the 1994 update would have been lower. The savings for this proposal over 6 years will be $2.975 billion. Beneficiaries will experience savings of about 25 percent of this amount through lower cost-sharing liabilities.

- **Eliminate the hospital outpatient overpayment.** Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal will eliminate the flaw in the payment methodology and the resulting overpayment, effective July, 1, 1994. The 6 year savings for this proposal will yield $12.61 billion.

- **Competitively bid for laboratory services.** Under current law, clinical laboratory services are paid on the basis of carrier fee schedules which are subject to national limits. We propose that clinical laboratory services be paid on the basis of competitive bidding as of January 1, 1995. Competitive bidding will help Medicare to obtain a price closer to the true market price, will allow changes in technology and other changes in input prices to be factored into the price structure directly, and will help Medicare get the same discounts now given to non-Medicare business. Savings for this proposal over 6 years will be $1.59 billion.

- **Competitively bid for certain durable medical equipment items, MRIs and CAT scans.** Currently Medicare is not paying market prices for these items, nor is there a reliable mechanism to determine such a price under current authority. Moreover, the GAO has reported that high Medicare payment rates for MRIs foster excess capacity by allowing providers to realize profits at low operational volumes. Competitive bidding will reveal the most efficient sources of supply and will establish market prices for these items and services. This proposal will yield a 6 year savings of $1.32 billion.

- **Increase income-related Part B premium**. Under this proposal, effective

January 1, 1996, beneficiaries with modified adjusted gross incomes over $90,000 and couples with adjusted gross incomes over $115,000 will pay a higher premium. The maximum premium will equal 75 percent of program costs. They will still receive a 25 percent subsidy. Under current law, all Medicare beneficiaries regardless of income who enroll in a timely manner, receive a subsidy from taxpayers equal to 75 percent of program costs, which will be about $1,600 in 1996. General taxpayers should not have to heavily subsidize the costs of health care of the nation's high-income individuals. This proposal will require high-income Medicare beneficiaries to pay a progressively higher Part B premium and establish more equity in the financing of the program. This proposal will produce $4.24 billion in savings over 6 years.

- **Re-establish a 20 percent coinsurance on all Part B clinical laboratory services**, effective January 1, 1995. Clinical laboratory services are the only diagnostic services under Medicare for which coinsurance does not apply. Physicians may now order an excessive amount of tests when they know that the service is free to the beneficiary. Reestablishing coinsurance will make cost-sharing requirements uniform across Part B. Coinsurance will provide incentives for the provision of appropriate tests. Six-year savings for this proposal will be $7.59 billion.

- **Extend SMI premium to finance 25 percent of program costs**. This proposal will extend the current 25 percent policy through the year 2000 and will save $3.81 billion over 6 years.

- **Limit payments to high-cost medical staffs**. As a national mechanism, the MVPS fails to adjust adequately for variations in physician practice patterns across communities or regions. Currently there is wide variation in Medicare's physician expenditures per admission across hospitals, even after adjustment for case-mix and price differences. This proposal will create incentives for medical staffs to deliver services more efficiently. Savings for six years will be $2.32 billion.

<u>Medicare Parts A & B</u>

The Health Security Act will achieve the following savings in both Parts A and B of the Medicare program.

- **Assure that OBRA 93 home health savings are retained.** OBRA 93 established a two year freeze on updates to the HHA limits. However a "catch-up" would occur when the HHA freeze expires on July 1, 1996. This proposal provides permanent savings by recalculating the percent of the mean that would produce the same amount of savings as if the freeze were continued. This proposal will result in a 6 year savings of $2.42 billion.

- **Switch from mean to median costs when calculating home health agency cost limits** for cost reporting periods starting July 1, 1997. In the case of HHA

costs limits, a few very high cost agencies can have the effect of raising everyone's limits. Moving to the median will produce limits that are more representative of typical HHA costs and encourage HHAs to achieve efficiencies. Six-year savings for this proposal will be $650 million.

- **Establish a copayment for home health visits** at 10 percent of average cost per visit for all visits except those occurring within a 30 day period following an inpatient hospital discharge. HHA expenditures have increased tremendously over the past few years, almost doubling between fiscal year 1990 and fiscal year 1992. For fiscal year 1994, the projected increase is nearly 33 percent. This proposal will provide Medicare beneficiaries with an incentive to reduce unnecessary utilization and seek the optimum amount of care. This proposal would be effective July 1, 1995 and savings over 6 years would be $8.59 billion for this proposal.

- **Expand Centers of Excellence** by contracting with individual centers using a flat payment rate for all Medicare services associated with cataract or coronary artery bypass graft surgery. The Secretary would also be granted authority to designate other services that might be appropriate for this approach. Medicare beneficiaries would be encouraged to use these centers by providing a rebate to the beneficiary equal to 10 percent of the government's savings from the center. HCFA has initiated two bundled payment demonstration projects involving CABG and cataract surgery that show potential for Medicare savings. By expanding this concept, Medicare will be able to reduce expenditures by $540 million over 6 years.

- **Permanently extend the Medicare secondary payer data match** (which OBRA 93 extended through fiscal year 1998) between HCFA, IRS and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare. The program identifies situations where Medicare made a mistaken primary payment rather than the secondary payment required under the law for certain beneficiaries. This proposal would save $525 million over 6 years.

- **Lower the Medicare secondary payor provision for the disabled from 100 to 20 employees.** For persons who are disabled, the current Medicare secondary payer provisions apply only if their employers have 100 or more employees. This relieves small employers of the financial burden of carrying health insurance with primary payer responsibility for disabled employees. This protection for small employers will become unnecessary under health care reform, which provides for universal coverage and standard premiums. This proposal will save $650 million over 6 years. Under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals because of community rating. A separate provision in the Health Security Act will require that all employer-based coverage provide primary coverage for those eligible for Medicare, including disabled workers.

- **Extend Medicare secondary payer provisions for the disabled.** Permanently

extend the provision making Medicare the secondary payer for disabled employees with employer-based health insurance. Extending this provision would allow Medicare dollars to be spent on services for individuals who do not have employment related health insurance coverage. Six year savings would equal $2.33 billion.

- **Extend Medicare secondary payer provisions for end-stage renal disease.** Permanently extend the provision requiring non-Medicare insurers to be the primary payer for ESRD patients for 18 months before Medicare becomes the primary payer. This provision would save $180 million. As with the MSP provision related to the disabled, the enactment of community rating will protect employers from vulnerability to higher premiums related to coverage of high-risk individuals. A separate provision of the Health Security Act addressing Medicare workers, spouses of workers, and their dependents would eliminate the 18-month time limit on employer plan coverage of individuals with ESRD.

- **Apply a ceiling and floor to risk HMO payments.** Under the current risk payment methodology, there is tremendous variation in payments by county, particularly in the Part B portion of the AAPCC. While factors such as the mix of teaching and disproportionate share hospitals can help explain some of the variation, the impact of other factors such as utilization remains unclear. This proposal would establish more equitable payments across the nation and, as a result, force certain plans to better manage service utilization. Savings for this proposal would equal $1.285 billion over 6 years.

New Revenue

The Health Security Act includes one Medicare proposal for new revenues.

- **Extend Hospital Insurance tax for State and local workers.** We propose to make the wages of employees of all State and local governments subject to the Medicare HI tax. About 20 percent of employees of State and local governments are exempt from the Medicare tax and often become entitled to Medicare based on short periods of covered work or a spouse's Medicare entitlement. These persons have not paid their fair share of taxes compared to most workers who pay into the HI Trust Fund throughout their working years. A study by the Inspector General found that 85 percent of the retirees of government agencies exempt from Medicare coverage are Medicare enrollees. The average contribution of these individuals was only 36 percent of the average for all Medicare beneficiaries. This proposal would raise $7.309 billion over a 5 year period.

Conclusion

The President's Health Security Plan includes important Medicare proposals that reinforce the program while, at the same time, reduce its rate of growth. We believe

these changes in the Medicare program are attainable and necessary for successful reform of the health care system as a whole. But the price of restructuring our health care system is a shared responsibility that will depend on the cooperation and contribution of physicians, hospitals, and other health care providers, as well as beneficiaries.

We do have the resources to meet the health care needs of all our citizens **if we spend our health dollars wisely**. With everyone's willingness to participate, we can afford universal coverage without compromising quality or limiting the availability of necessary health care services for the elderly population or any other population in our country.

I look forward to working with you in the months ahead to forge a consensus on health care reform that promotes the improved health status of our citizens and strengthens our national productivity.

Medicare Savings Under Health Reform ($ in millions)

16-Nov
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	1995	1996	1997	1998	1999	2000	TOTAL 95-2000**
Part A							
Hospital Update at MB-2 '97-2000	0	0	(930)	(2,870)	(5,610)	(8,750)	(18,160) *
Reduce Indirect Medical Education Adjustment	0	(2,470)	(3,110)	(3,470)	(4,130)	(4,660)	(17,840) *
Reduce Medicare Payments for Capital	0	(995)	(1,400)	(2,005)	(2,610)	(3,315)	(10,325) *
Phase Down DSH as States Enter HCR System	0	(430)	(1,330)	(3,670)	(4,390)	(4,810)	(14,630)
Prohibit PPS exemptions for new LTC hospitals	(20)	(40)	(70)	(100)	(130)	(170)	(530) *
Extend OBRA '93 SNF Savings	0	(80)	(160)	(180)	(200)	(210)	(830) *
GME Lag	0	30	60	150	20	20	280 *
HI Interactions	0	0	110	300	510	730	1,650 *
Subtotal, Part A	(20)	(3,985)	(6,830)	(11,845)	(16,540)	(21,165)	(60,385)
Part A Revenue Proposal							
State and Local Employees: Net of Offset	0	(1,535)	(1,518)	(1,470)	(1,420)	(1,366)	(7,309)
Part B							
Real GDP Per Capita V&I Factor	0	0	(275)	(1,075)	(1,975)	(2,775)	(6,100) *
Set Cumulative Growth Targets	0	0	85	(1,825)	(2,475)	(1,600)	(5,815) *
Reduce CF by 3% in 1995, Except Primary Care	(250)	(475)	(525)	(550)	(575)	(600)	(2,975) *
Eliminate Formula-Driven Overpayment**	(1,050)	(1,300)	(1,690)	(2,190)	(2,750)	(3,480)	(12,610) *
Competitively Bid for Medicare Labs	(140)	(220)	(260)	(290)	(320)	(360)	(1,590)
Competitively Bid Part B Services	(110)	(190)	(210)	(240)	(270)	(300)	(1,320)
Income Related Premium: Net of Interactions	0	(350)	(935)	(900)	(985)	(1,070)	(4,240) *
Reestablish 20% Lab Coinsurance	(650)	(1,070)	(1,230)	(1,380)	(1,540)	(1,720)	(7,590) *
Extend 25% Part B Premiums: Net of Interactions	0	710	1,090	2,140	1,000	(1,130)	3,810 *
Limit Payment to High-Cost Medical Staffs	0	0	0	(500)	(780)	(1,040)	(2,320) *
Prohibition on Balance Billing	0	130	250	260	270	290	1,200 *
Subtotal, Part B	(2,200)	(2,765)	(3,700)	(6,550)	(10,400)	(13,785)	(39,550)
Parts A & B							
Extend OBRA 93 Home Health Savings	0	0	(480)	(600)	(650)	(690)	(2,420) *
Establish Home Health Median Limits	0	0	(10)	(160)	(230)	(250)	(650) *
10% HHA Copay except 30 days post-discharge	(230)	(1,400)	(1,560)	(1,680)	(1,800)	(1,920)	(8,590) *
Expand Centers of Excellence							
Part A	0	(60)	(70)	(70)	(70)	(70)	(340)
Part B	0	(40)	(40)	(40)	(40)	(40)	(200)
Extend OBRA '93 MSP Data Match	0	0	0	0	(195)	(330)	(525) *
MSP Disabled: 100 to 20 employees	0	0	0	(150)	(240)	(260)	(650) *
Extend OBRA '93 MSP for Disabled Provision	0	0	0	0	(990)	(1,340)	(2,330) *
Extend OBRA '93 MSP for ESRD Provision	0	0	0	0	(75)	(105)	(180) *
HMO Payment Improvement	(30)	(90)	(165)	(250)	(350)	(400)	(1,285) *
Subtotal, Parts A & B	(260)	(1,590)	(2,325)	(2,950)	(4,640)	(5,405)	(17,170)
TOTAL PACKAGE	(2,480)	(9,875)	(14,373)	(22,815)	(33,000)	(41,721)	(124,414)

* Indicates OACT Pricing

** Includes $150 million in FY 94 Savings from the Formula Driven Overpayment Proposal

Mr. WAXMAN. I would like to start off the questions. As you note in the outset of your testimony, we are about to face a very serious challenge to our health reform efforts in the form of this Penny-Kasich amendment.

You stated this amendment, which would cut $37 billion in Medicare outlays over 5 years, does not represent good economic policy and will hurt the prospects of deficit reduction and health care reform. However, yesterday, I received a dear colleague letter from Members of the House who are supporting this amendment. They say, and I quote, "We are told that trying to slow down Medicare spending at this time will undermine health care reform. This is a stretch. The administration claims to have a cushion of $45 billion in its health care reform plan. Therefore, even if our amendment were enacted, the administration's proposal still would have a very comfortable cushion." End quote.

Now, my question is, what do you say to those who point to those savings in the President's plan as evidence that we can afford these Medicare cuts for deficit reduction without undermining the financing of your health reform plan?

Mr. VLADECK. Mr. Chairman, there are a number of reasons why I would disagree with those statements and why we think that passage of these proposals would be destructive from the point of view of health care reform. With your indulgence, let me enumerate them very, very briefly.

First, as we have said on many occasions, and as we continue to feel very strongly, as we said during the course of the reconciliation process, we believe that further reductions in Medicare outlays are defensible only in the context of reduction in private sector outlays at the same time. Certainly when one is talking about payments to providers but as well when one is talking about the structure of benefits, we do have the problem that has developed over the last several years in which the limited success we have had in controlling the rate of growth in Medicare provider payments has created the problem with an unconstrained growth in the private sector of this growing differential between what we are paying and what the private sector is paying and what private sector benefits look like and what Medicare benefits look like.

We believe in the context of a program which brings private sector rates of growth down to significantly more realistic levels, and which establishes a reasonably standard set of expectations about the benefit package, it then becomes possible to achieve further savings in the Medicare program, particularly on the provider payment side, by deceleration in the rate of growth of Medicare less dramatic than we are seeking in the private sector.

But to do it on the Medicare side only runs the risk of turning Medicare into a second class program, the so-called "medicaidization" of the Medicare program in terms of access to services and benefits on the part of our beneficiaries.

Second, in that regard, you note, as you have a chance to study other tables more, that only a relatively small fraction of all the reductions in Medicare outlays we are proposing in our proposal will directly affect beneficiaries. There are some very significant benefits to beneficiaries as well as cuts to beneficiaries. All of the Penny-Kasich cuts involve increased payments or costs for bene-

ficiaries, and we think that is disproportionate and inappropriate and inconsistent with the notion of shared responsibility or shared burden, shared sacrifice in terms of health care reform.

Third, further on that point, I guess, in a way, we propose to use the money we are saving from reduction in the rate of growth of Medicare provider payments to pay for new benefits in the Medicare program. We think there is a fundamental equity in doing so. We think a failure to do so would be breaking faith with America's seniors, in particular.

In terms of their continued willingness to support expanded coverage for the nonelderly and folks who do not now have universal coverage provided, we begin to move towards a level playing field in terms of the benefits of Medicare as opposed to benefits in the private sector. Financing of prescription drug benefits does that. Merely shifting more costs in the program to beneficiaries, as Penny-Kasich would do, clearly does not do that.

Finally, I think it is very clearly contained in the rationale for the President's health care reform proposal that long term—in order to control the Federal deficit, in a number of ways it is necessary to control the rate of growth in health care costs, not only because of the public outlays associated with it but because of the impact on health care costs, on the private profits, private wages, and revenues received from the internal revenue system.

The deficit reduction called for in the President's proposal, in that sense, if you look at the timing of when it emerges over the life of the budget window and how it comes about is really an effect, not a cause, of the deceleration in the rate of health care inflation throughout the economy as a whole, which is necessary, we believe, for long-term deficit reduction. Taking additional short-term hits in the Medicare program moves us in the opposite direction.

Finally, if I could refer very quickly to this issue of the cushion, there has been a lot of talk about that but we find it a little bit difficult to respond simultaneously to the arguments, that in making the budgetary and financial estimates associated with the President's health care reform proposal we have not been sufficiently cautious or sufficiently conservative from an actuarial point of view and then to be told simultaneously there is a cushion in our numbers which could be spent on something else.

Mr. WAXMAN. Well, it sounds to me like this Penny-Kasich amendment can do a tremendous amount of damage to your efforts to get health care reform and to make sure that the Medicare program does not get in the position where it is going to be disadvantaged vis-a-vis health care for everyone else in this country.

Mr. VLADECK. It is an enormous step backwards, we believe, in terms of trying to get health care reform.

Mr. WAXMAN. Let me ask you about, assuming there were no Penny-Kasich, I have this same kind of concern for how the President's proposal is going to handle Medicare. What worries me is the magnitude of the $124 billion Medicare cuts in the President's bill and that is, of course, coming on top of $56 in program cuts we just enacted in this year's deficit reduction bill.

While there does not appear to be evidence of systematic access problems for Medicare beneficiaries, all of us are hearing anecdotes about physicians closing their practice to Medicare patients. The

problem is that we do not want to wait for such evidence to accumulate before we realize we have gone too far.

You indicated there is a large gap now between what Medicare pays for services and payments by private payers. The Physician Payment Review Commission, from whom we will hear a little later, will testify that in 1993 they estimated that, on average, Medicare pays well below 70 percent of comparable payments by Blue Cross/Blue Shield plans. In comparison to commercial insurance plans it is even more dramatic, with Medicare rates averaging less than 60 percent of commercial rates in 1991.

These findings are alarming and they certainly suggest we should move cautiously in making any further reductions in Medicare rates. My question is can you tell us whether these Medicare savings in the President's package will widen this gap, narrow it, or leave it about the same; and do you think it is possible that we may repeat the experience of Medicaid in many States where there is simply not enough physicians willing to serve Medicaid beneficiaries?

We certainly do not want Medicare to become like Medicaid.

Mr. VLADECK. No, Mr. Chairman. And, again, I feel very strongly that these cuts in provider payments would not be defensible in any magnitude were they not in the context of even more dramatic reductions in the rate of increase in private sector expenditures.

In terms of what we would anticipate happening to the differential between Medicare payments and private sector payments under health care reform, using the numbers we have laid out, I think the situation will be somewhat different between the physician side and the hospital side. To begin with, the existing differential on the hospital's side is not as great as it is on the physician side.

But, second, there is so much overcapacity in the hospital sector and we believe that changes under health care reform will continue to put pressure on that capacity that we think Medicare will still be a very good deal for most hospitals and that hospital rates, because utilization is down so substantially, will grow for Medicare and the private sector roughly comparably.

On the physician side, there is going to be enormous pressure on the part of physicians to move more and more of their practice into capitated or discounted or other managed care kinds of arrangements relative to a fee-for-service nondiscounted payer, even as the list price, or lower, becomes increasingly attractive over time.

Further, as more people move into managed care arrangements, we expect there will be substantially more competition on the price side among specialists of all sorts which will significantly drive down their fees in the private sector.

Mr. WAXMAN. Let me ask you——

Mr. VLADECK. We would expect, in aggregate, the differentials to shrink under these proposals not to increase.

Mr. WAXMAN. That would be comforting if that is the result. But let me ask you about the transition phase, because I want to be sure these Medicare cuts are coordinated with the transition to universal coverage.

It seems critical to me that we are careful not to make new and deep cuts in Medicare payments before we achieve universal cov-

erage, otherwise, we are likely to put at risk those vulnerable institutions and practitioners who are continuing to serve large numbers of unsponsored patients.

Could you respond to that point? The transition: Are we being careful on this transition?

Mr. VLADECK. We are trying to be, Mr. Chairman, and to the extent we have not got it all right yet, of course, we would be happy to work with you. But the most obvious case is the reduction in the Medicare disproportionate share payment to hospitals, which is tied in our proposal, and in all our budget estimates, to the implementation of health care reform on a State-by-State basis. So that at the point in which a State institutes universal coverage, thus presumably eliminating much of the need for disproportionate share payments, those disproportionate share payments phase down in that State.

We have a somewhat less elegant, but I think still carefully phased solution on the indirect medical education reductions and some of the other provisions of this plan.

Mr. WAXMAN. Thank you, Mr. Vladeck.

Mr. Bliley?

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Vladeck, as you know, rulings and regulations of the Treasury Department and IRS interpreting tax statutes passed by Congress are subject to challenge in various forums, such as the U.S. district courts or the U.S. tax courts. Taxpayers could raise challenges to these rulings and regulations in an administrative setting. That is why we are very concerned about a provision buried in the Health Security Act in section 5232 on page 906 of the bill which reads: Quote, "There shall be no administrative or judicial review of any determination by the National Health Board respecting any matter under subtitle A of title VI." Unquote.

Under subtitle A of title VI the National Health Board, makes determinations regarding the alliance health premium caps and, therefore, sets the premium amounts that employers and individuals will have to pay throughout the country. Why are individuals and employers not given the same opportunity to challenge measures taken by the National Health Board setting premium payment responsibilities as they are given with respect to regulations and rulings of the IRS and the Treasury?

In addition, this seems to be a particularly contradictory policy with respect to other provisions of the Health Security Act, which provides private rights of action to enforce State responsibilities, Federal responsibilities, and to enforce responsibilities of the alliances. Could you please comment?

Mr. VLADECK. I will try, sir, and if I don't fully understand the question, we will try to get you a written answer back. But if I understand it correctly, the passage to which you are referring refers to the establishment of a premium cap by the National Health Board. The real analogy would be to the establishment of the discount rate on the part of the Federal Reserve Board where one may sue a bank if it discriminatorily denies you a merger, a mortgage, or a line of credit but where the setting of national interest rates by the Federal Reserve Board is not subject to judicial review.

Similarly, in one sense, a national target for the growth in premiums, how that target actually affects an individual's health plan or the premium the individual pays, the premium their employer pays, depends on a lot of intermediate decisions by a lot of intermediate institutions which are subject to appeal and review under the proposal.

Mr. BLILEY. Well, it does not seem to me to be consistent. Are you going to allow private rights of action against States, the Federal Government, and the alliances but at the same time you are going to say this board is beyond review? They set a cap and that is it? I don't follow.

Mr. WAXMAN. We are being interrupted with a vote. We have given each member 10 minutes. You have consumed 3 minutes and you should get 7 minutes after the break, if we can respond to the vote and then come back.

Mr. BLILEY. OK.

[Brief recess.]

Mr. WYDEN [presiding]. The subcommittee will come to order and let us proceed with the questioning of the gentleman from Virginia.

Mr. BLILEY. Mr. Vladeck, I invite your attention to this chart over here on your left. The chart examines the structural ways that payments are capped. These cap payments will place incredible strains on both the alliances and its health care plans, since both coverage and benefits are federally guaranteed. Let us examine these various caps.

First, there is a CPI cap on the Federal and State payments for cash-eligible Medicaid recipients. According to your own figures, this cap cuts Federal Medicaid payments from cash eligibility by $22.3 billion. Second, the bill has a premium cap on private health care premiums, which is at the CPI when fully phased in. Third, there is also a cap on Federal payments for Medicare recipients who have been integrated into State single payer systems or regional alliances.

Finally, the subsidy payments for small businesses and low-income families is capped in statute at section 9102(e). The alliance and its health plans are placed in a very peculiar position. While all of its sources of revenue are capped, it must provide an open-ended entitlement to all individuals who subscribe.

[The chart referred to follows:]

Program Caps in Administration Bill

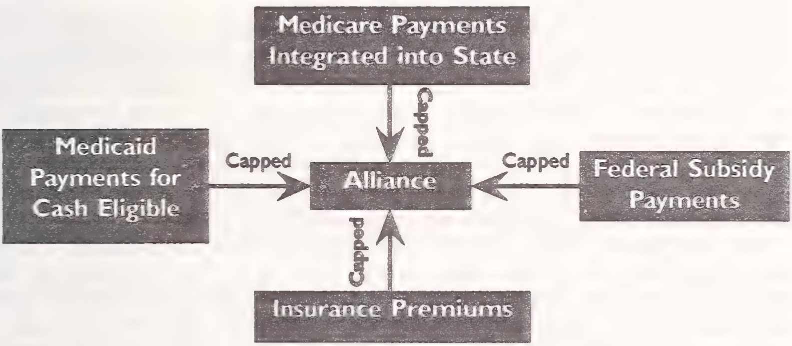
Cap on Medicaid cash eligibles:
When cap is fully phased in → **CPI CAP**

Administration Estimate of Savings From Cap on Medicaid Cash Eligibles (In Billions)

FY '96	*FY '97*	*FY '98*	*FY '99*	*FY 2000*	*Total*
-$3	-$1.2	-$3.9	-$6.7	-$10.2	-$22.3

Premium Cap on private health insurance premiums:
When cap is fully phased in → **CPI CAP**

Cap on payments for state integration of Medicare beneficiaries in single-payer systems and regional alliances:
When cap is fully phased in → **CPI CAP**



Mr. BLILEY. Mr. Vladeck, has this system got a guarantee for insolvency?

Mr. VLADECK. Sir, I don't believe so. I think the alternative is national insolvency. The fact of the matter is that unless we are going to find ourselves in a situation in which the cost of health care drive out all other new expenditures and other new investments from the economy and which the cost of health care make the Federal budget deficit a permanent phenomenon, we are at some point going to have to control the rate of growth in health care expenditures.

The fact is there are two ways to do that. One is you can have a national system of price controls and the other is you can attempt to reorganize the health care system in such a way that the decision-making is left as much as possible at the local level in local communities, local plans, among local providers, and that is what the President's proposal proposes to do.

In the economic models we have done, we have 1 year, I believe, perhaps 2, in which the rate of growth is set at the CPI on a decelerating slope. We have also assumed that after the year 2000 it will probably be necessary to acknowledge a somewhat higher rate of growth to account for long-term demographic and population trends.

But the alternative to caps of this sort is to say that as a society we are incapable of controlling the growth of the share that health care costs occupy in our total national expenditures, and we consider that an unacceptable alternative.

Mr. BLILEY. I can understand what you say, Mr. Vladeck, as far as trying to get a handle on the cost, but on the one hand you are putting a cap on there and on the other hand you are saying we are creating this open-ended entitlement.

You are going to—for example, you say that you are going to provide health care insurance as a new entitlement for anybody 55 to 65 who is retired. Every time we create one of these entitlements, we historically, historically, underestimate the cost tremendously and then overestimate the amount of money you will save. So I think if you are going to cap all those things, and you maintain that cap, while at the same time you make no attempt to control the entitlements, you have an impossible situation.

Mr. VLADECK. Well, sir, I don't believe it is impossible. I believe there are two ways out, as it were. One is in basic economic terms we can put some expectations that the health sector will increase its productivity. The alternative way out is to accept a deceleration in the rate of growth of incomes of providers in the health care sector.

What we are saying is that we expect at some point the health care sector in the United States to be put on a budget, and it should not meet it budgets the way we have in the past, by kicking people out or by denying them benefits. I think that is entirely a defensible position.

Mr. BLILEY. We will see. Thank you.

Mr. BROWN [presiding]. Thank you.

Mr. Vladeck, currently Medicare does not cover preventive services, preventive care for the elderly. Despite the administration's overall goal in designing a plan to encourage people to obtain pre-

ventive services, they have talked to us a great deal about other kinds of preventive care, everything from immunizations to wellness, wellness on the work site, that sort of thing. These types of benefits are not added to that part of the package.

Comment on that for us, if you would; if you have plans to do that or if there are ideas you might have that would cover preventive services.

Mr. VLADECK. I appreciate that question. I think it is a very valid one.

We are not entirely—we do not entirely fail to cover preventive services under Medicare. As you know, we now cover flu shots as well as Hemophilus influenza shots and screening mammographies, and we have worked with the Congress to expand the availability of preventive services for Medicare beneficiaries on an item-by-item basis.

I agree, it probably makes sense to take a more systematic look. I must tell you, however, that there are two things arguing against the urgency of doing so, as it were. First, there are not that many services which we are not now covering for the Medicare population where we can demonstrate cost effectiveness for the coverage of preventive services.

Second, the most important set of preventive services which are cost effective among older people are those that involve a regular physician visit, and particularly routine screening as part of those visits, for blood pressure and for colorectal cancer and so on and so forth. And our presumption is, looking at our claims data, a very large portion of Medicare beneficiaries are getting those services anyway.

Mr. BROWN. As I read the bill, it appears that newly eligible Medicare beneficiaries will have a choice to remain in health alliances while current beneficiaries will remain as we know it today; correct?

Mr. VLADECK. That is correct.

Mr. BROWN. Assuming people will move around until they are happy with their health care, one would assume by the time one becomes eligible for Medicare that that person would be fairly satisfied with their alliance plan and potentially less likely to change plans.

Does that mean that this plan by design would create a Medicare that is high cost because the program would ensure the oldest and the sickest patients?

Mr. VLADECK. That would be a real danger, sir, if we did not refine, as we are already planning to do anyway, our payment methodology for the risk contract for those folks who are retired but choose to stay in the alliances.

For folks who are working and remain in the alliances or are working part time or are dependents of workers, in fact, there is no real change from the current policy where we have encouraged working beneficiaries to keep their employment-related coverage as a way of saving Medicare a substantial amount of money.

For the folks who retire and propose to stay in the plans, there is a problem of this shift in relative risk to the Medicare program unless we refine our payment methodology for those folks who stay

in the alliance plans and pay something closer to their real actuarial cost.

Mr. BROWN. I am going to recess for just a moment. People can remain seated. I think Chairman Waxman will be back very, very shortly. The recess is for probably no more than 5 minutes so that I can vote and others. Thanks.

[Brief recess.]

Mr. KREIDLER [presiding]. Mr. Vladeck, I rushed back hoping I would have the opportunity to ask a couple of questions.

As you probably know, outpatient hospital services are now subject to a 20 percent beneficiary copayment but the copayment is based on the hospital charge, not the amount that Medicare allows as its payment, and that results in additional costs to beneficiaries.

The largest of the proposed part B reductions, "elimination of formula-driven overpayments for outpatient hospital services," is related to this issue. Can you explain that change to us and can you tell us what the effect would be on beneficiaries' out-of-pocket costs over time?

Mr. VLADECK. I will try, sir. I can explain, I think relatively succinctly, what our proposal is and how it affects beneficiaries. If I try to explain this whole issue having to do with outpatient payments and the formulas, it is the most complicated issue I have ever dealt with, and the odds are I will not get it entirely right but I will try by a brief summary.

We have a statutory payment formula for outpatient radiology inventory surgery and a few related outpatient services, which, in retrospect, we believe was probably, the exact language was probably erroneous. So we have the following problem: The beneficiary's copayment is 20 percent of the hospital's charges, but in fact what we pay the hospital is a blend of the hospital's actual costs for those services and the price we would pay for the same service in a freestanding setting, such as a freestanding ambulatory surgical center.

However, in deducting, in compensating for the amount of copayment the hospital has received from the beneficiary, since it collects that first in most instances, there is an error in the formula that, in effect, causes the hospital to get paid more from us than they should have been by subtracting out the beneficiary's actual copayment from what we are obligated to pay them. As a result of which we are overpaying the hospitals and the hospitals are over collecting and we are proposing to fix that in this set of proposals under the so-called formula-driven overpayment with significant savings as a result.

Now, that does not solve the other problem associated with this policy, which is that beneficiaries are paying 20 percent of charges which for outpatient services tend to be significantly more than 20 percent of cost, and even more, relatively speaking, to 20 percent of what the hospital is getting paid for those services. We are not proposing to do anything about that directly in these proposals, frankly, in large part for two reasons.

One is we are proposing to bring you proposals for more comprehensive reform of outpatient payment under the Medicare program. We have a report to the Congress that is significantly overdue, having gotten caught up in issues of transition and change of

administrations, which we hope to release to you relatively soon and which will speak to strategies for addressing this problem.

Second, it has significant economic implications as well. There is some limited help for the beneficiaries in our proposal to the following extent: Because of the way this is now working, hospitals have an incentive to raise their charges for outpatient services as quickly and as fast as possible.

Since their payments will no longer go up under our proposal, as their charges go up, the incentive to continue to increase their charges and thus increase what the beneficiaries have to pay is substantially reduced. So there is some protection for beneficiaries prospectively from these proposals. But we would not claim it is a total solution to this problem.

Mr. KREIDLER. I guess I have a little trouble understanding how that is going to protect my Medicare eligible constituents.

Mr. VLADECK. Let me give you an example, if I can. You may now have——

Mr. KREIDLER. The hospital, it seems to me, has every reason to make up what they are not receiving from the Federal Government by making these adjustments.

Mr. VLADECK. Well, let me give you an example now, if I can. If a hospital—now it costs them $100 to provide a particular service and their charge for that service is $250, the 20 percent copayment the beneficiary is making is now $50. If we are paying them $100, we should be paying them $100. We are actually only paying 80 percent of that $100 at the moment. So the hospital altogether is collecting $130 instead of the $100, and they collect more money if they raise their charges to $300.

Under our proposal, if it is enacted, the total revenue the hospital receives from the beneficiary plus the Medicare payment for that service will not change if they raise their charges because any increase in what they collect from the beneficiaries will produce a dollar for dollar reduction in what Medicare pays.

It does not fix the fact that beneficiaries are already overpaying for that service, but it does remove the incentive for the hospital to increase the charge for that service, because to the extent they do and take it from the beneficiaries, we will take it back.

Mr. KREIDLER. You are confident that that is going to result in not seeing more costs shifted to the beneficiaries?

Mr. VLADECK. Again, sir, we have not totally fixed this problem with this proposal, and it is sufficiently complicated and sufficiently dynamic that I am not sure I would use the word "confident" to describe our perception of this, but we are hopeful that this will significantly reduce the rate of increase of cost for the beneficiaries for this problem.

Mr. KREIDLER. Very good. I have a proposal from a physician in my State who feels that Medicare should provide routine feedback to primary care doctors on the cost of other services they have recommended for their patients.

For example, an internist who hospitalizes a patient and orders some tests and recommends surgery should get a routine report on what all of those services cost. That would be a small step toward more cost consciousness in this fee-for-service environment that we

currently have. It could become a foundation for financial incentives for physicians to avoid unnecessary expenses.

Would the administration be receptive to this idea, and is it technically feasible?

Mr. VLADECK. Sir, if I can answer your questions, first of all, I believe it is technically feasible; I am not certain it is legally feasible. That has to do with the issue of releasing physician-specific information from our Medicare claims data base, which is the one, a class of provider-specific information under which there is a history of case law restricting our ability to distribute it.

I am not familiar with the details of that proposal so I am not certain whether in this instance we would have the authority to release that kind of information. We would certainly be happy to inquire.

In general, the general principle of having the primary care physician know not only about the clinical outcomes but the economic outcomes of the decision they make, I think, is a valid one, and if your constituent would like to talk to us about ways of testing that, we would be interested in talking to him to explore what we could do.

Mr. KREIDLER. You would not necessarily be opposed to us granting the legal authority so you could release that information?

Mr. VLADECK. Offhand, I would see no reason why we would have a problem with that.

Mr. KREIDLER. Very good.

Mr. KREIDLER. Thank you very much. I want to turn now to Mr. McMillan.

Mr. MCMILLAN. Thank you very much.

I would like to get back on the same subject again. I don't think we have clarified that in the public's mind.

I have a handout we have put out there, which is signed by Charles Stenholm and myself, which was mailed around to Members of Congress this morning on the issue that we are discussing with respect to Medicare savings under the Penny-Kasich proposal, which I would like to review with you.

[The information referred to follows:]

ALEX McMILLAN
9TH DISTRICT
NORTH CAROLINA

ENERGY AND COMMERCE COMMITTEE
BUDGET COMMITTEE
REPUBLICAN LEADER'S TASK FORCE ON HEALTH
REPUBLICAN LEADER'S TASK FORCE ON THE ECONOMY

Congress of the United States
House of Representatives
Washington, DC 20515-3309

November 17,1993

BOGUS ARGUMENTS AGAINST PENNY-KASICH

Dear Colleague:

The arguments against the Penny-Kasich amendment in the name of preserving savings for health care reform are bogus, plain and simple.

Consider the following:

CLINTON HEALTH CARE PLAN

	SAVINGS	EXPANSIONS UNDER PLAN
1. MEDICARE	+$124 BILLION	-$131 BILLION
2. MEDICAID	+$65 BILLION	-$65+ BILLION

In addition, the Clinton health plan makes the following assumptions:

3. TAX HIKES	DEFICIT-REDUCTION	-$58 BILLION
	"CUSHION"	-$45 BILLION
+$90 BILLION	TOTAL	-$103 BILLION

This is roughly how the Clinton health plan would work out on a ledger sheet. Their Medicare "savings" will be immediately spent on new expansions of Medicare, primarily in long-term care and prescription drugs. The Medicaid "savings", primarily from the elimination of the Disproportionate Share Program (DSH), plus the state share, would be spent immediately on expansions of Medicaid.

The only way the Clinton health care plan can achieve any deficit-reduction or "cushion" is if they pass $90 billion of new tax increases, roughly $65 billion on tobacco products plus $25 billion on surtaxes on corporate health plans and other corporate changes.

All the Penny-Kasich amendment would do is initiate firm savings by means-testing Medicare and extending uniform copayments on certain Medicare services and apply them towards reducing the deficit NOW, not later. Medicare savings of $31 billion now under Penny-Kasich could reduce the deficit now and still leave $27 billion for the Clinton plan to reduce the deficit further if or when it passes.

This proposal does not take away any of the President's program options. Penny-Kasich only makes these savings in advance.

Last weekend, the Administration stated that they were opposed to the Penny-Kasich plan because it would interfere with their "carve-and-spend" plan for the existing budget. We prefer to "carve" those savings out of the federal turkey and "save" them by reducing the deficit, our nation's biggest persistent problem, in case you have not noticed it yet. Our constituents have.

"Spending" these budget savings on reducing the deficit would be the best long-term investment we could make for "growing" our economy, as the President likes to say.

Let's do something different for the American people this holiday season. Let's show them that this institution can work on a bipartisan basis and pass Penny-Kasich to save them $103 billion of federal spending over the next five years. That should be plenty to give thanks about.

Sincerely,

Alex McMillan
Member of Congress

Charlie
Charles Stenholm
Member of Congress

Mr. McMILLAN. It is correct to say, I believe, that Medicare savings proposed in the Clinton plan are $124 billion. No dispute of that. The proposed expansions under the Clinton plan are $131 billion in Medicaid, there is $65 billion in "savings", so-called, and we will admit they are essentially transferred into other aspects of the program, and so the spending under Medicaid will be $65 billion plus. We do not know precisely what that number is but that is not at issue here today. The tax hikes included in the proposal are some $90 billion by our figures.

I also have before you, Mr. Vladeck, a chart prepared by Ken Thorpe, that was presented here previously, which for those of you who have not focused on it, does project in the President's plan a $58 billion deficit reduction as a result of the health care plan over 5 years, plus a cushion of some $44 billion to $45 billion, which you discussed previously of $103 billion.

If anyone wants to question those things later, I would be glad to deal with them, but that is the administration's numbers.

It is also true that the $35 billion worth of reductions in Medicare outlays or net outlays that are included in the Penny-Kasich plan are essentially duplicative of those that will be included in the President's plan. In fact, the President will expand on them even further. They may not be exact but they are pretty close. I have not seen the details on the President's plan, but just looking at three line items in it this morning, they come pretty close to the same thing.

These are not spending reductions, which has been asserted in here this morning. They are changes in copayment and the proportion that the insured will pay of their premiums. Individuals whose income is in excess of $70,000 a year would only have to pay $146 a month for comprehensive health insurance.

Now, that may not be politically popular with those of us who like to think that people with $70,000 or more income vote for us and do not want to pay any share of anything, but this is not cutting spending. This is not depriving other programs of revenue that need to be taken care of. And I think that needs to be made clear.

The fact of the matter is, and I will give you, Mr. Vladeck, a chance to respond to this, that we are taking essentially the same savings that the administration is going to propose and simply advancing them 12 months. The impact of those in the first year will probably be less than $3 billion, which is only one-third of what the President's rescission package is, which is woefully inadequate, that he is putting up here this week. So if that has adverse economic effects, we are talking about a pig in a poke.

What I am concerned about here is that this thing is being put forth like a used car salesman that comes in here and offers you a higher exchange value on your used car and simply raises the price on the new car and the net effect is not going to be any different. There are those of us who think, economically, that it is very important to do what we did not succeed in doing in the budget package with respect to deficit reduction, which was inadequate.

And even the President's own health care plan acknowledges that deficit reduction is an important objective so much so that it includes $58 billion of "savings". If we simply use $35 billion of

that now, the only thing it does is to simply leave the net of that available for deficit reduction when and if this plan is enacted.

So, that I would like to have in the record and ask if you would like to respond to that any further?

Mr. VLADECK. Well, let me just make two points, if I could, sir, because I don't believe I am going to answer your questions this morning, but I would like to respond to a couple of the points, if I could.

You said two things I don't believe are entirely consistent with one another, and, one, that the Medicare cuts in the Penny-Kasich package are essentially duplicative of cuts that we have recommended, at the same time you have said they are not really cuts in spending, they are an increase in fiscal responsibility on the part of beneficiaries. I think those two statements are largely contradictory.

We have proposed a number of increases in costs for beneficiaries. They are very modest, and as I emphasized this morning, they are offset by reductions in the rate of growth of the part B premium and they are offset by substantial new benefits. We think that is fundamentally a different deal to be talking about than talking about just furthering——

Mr. MCMILLAN. Where is the $58 billion worth of deficit reduction coming from in the President's proposal?

Mr. VLADECK. The $58 billion worth of deficit reduction, as I suggested earlier this morning, comes from a reduction in the rate of growth of health care costs, which produces higher wages, higher corporate profits, and higher incomes throughout the economy by the end of the budget window.

Mr. MCMILLAN. It does not come from the fact you increase taxes by $90 billion?

Mr. VLADECK. Most of the taxes, again, in the package, where the pieces are interconnected, go to pay for discounts in subsidies for folks who are currently uninsured and for employers who are now paying more than 7.9 percent of payroll for health benefits, or small employers who are not currently providing benefits who would be receiving discounts under the proposals.

Mr. MCMILLAN. If you take away higher corporate profits, it does not show up in government accounts. We are talking about government accounts here, and I think this is political hogwash and doubletalk.

Mr. VLADECK. Higher corporate income taxes show up in government accounts. That is about $25 billion in increased tax revenue in the——

Mr. MCMILLAN. Let me go to some real cost problems which we have out there, which the health care proposal acknowledges exist, but I am not sure the President is really dealing with them.

We talked a little while ago about Surgeon General Koop's estimates that 20 percent of diagnostic and therapeutic cost were unnecessary. A big chunk of this is defensive health care costs and terminal health care costs in which the marginal condition of the beneficiary is not altered.

To what extent do your Medicare proposals reflect the savings that you claim that you are going to make by reason of your malpractice reform proposals and other controls that would actually re-

duce the cost of Medicare to patients and to hospitals that have to live under the regime the Federal Government set up? Is there an analysis of that?

Mr. VLADECK. We don't believe malpractice contributes significantly to Medicare costs so that we have——

Mr. MCMILLAN. I think you believe that, because your proposal is not strong enough to deal with it.

Mr. VLADECK. All the most recent data we have on that is the study sponsored by the American Medical Association which shows, including both the direct costs of the malpractice system and the indirect costs associated with defensive medicine cumulatively account for less than 5 percent of total health care costs. We know that Medicare——

Mr. MCMILLAN. What about pharmaceuticals? What do you think is the product liability exposure to pharmaceutical companies with respect to drugs? You do not have a product liability reform measure in your proposal, do you?

Mr. VLADECK. No, we do not.

Mr. MCMILLAN. Do you think Surgeon General Koop is wrong in estimating that 20 percent of health care costs are unnecessary?

Mr. VLADECK. No, I don't. But we do not believe they should be eliminated by Federal micromanagement of health care providers.

Mr. MCMILLAN. You do not?

Mr. VLADECK. We think they should be eliminated by getting the incentives right for cost containment.

Mr. MCMILLAN. Thank you. I yield back.

Mr. KREIDLER. The gentleman from Oregon.

Mr. WYDEN. Thank you very much, Mr. Chairman.

First, let me say I have great respect for the gentleman from North Carolina. I think he has been key to getting a good health care reform bill, but I want to say I am of the view that Penny-Kasich is essentially a back-door attempt to derail health care reform.

What we have is a situation where Penny-Kasich is going to suck all the dollars out that we need for a real overhaul, and then, when that is done, some of the defenders of the status quo will say, gee, we really do not have a lot of money here, so let's have a little small market reform effort.

So I appreciate very much your comments on the Penny-Kasich issue, and let me ask you about one administrative aspect of Penny-Kasich, Mr. Vladeck. You heard my comments earlier about how Medicare is a nightmare for a lot of seniors. They end up calling their kids to sort out these Medicare bills. The kid may be an accountant and they still cannot figure it out.

It seems to me Penny-Kasich makes the administrative issues associated with Medicare even worse. For example, as I read Penny-Kasich, they want to put in a Medicare part A hospital deductible that would be income related. Now, you talk about a paperwork nightmare. I mean, the kind of paperwork that would be associated with tying an income related change to the deductible—seems to me you are talking about medigap policies and all kinds of things. Wouldn't this be a significant administrative burden?

Mr. VLADECK. Yes. I don't know if the administrative costs of administering that kind of means testing on the part A deductible

would exceed the ostensible savings but they would be in the same ballpark.

Mr. WYDEN. But there is no question, if you were to go to a deductible, you would have additional paperwork and forms, not just on the government side but affecting all the medigap policies as well; would it not?

Mr. VLADECK. That is absolutely correct.

Mr. WYDEN. All right. The other question I wanted to ask you all about is the way I add up your figures, you all are proposing to take $27 billion out of Medicare before September 30 of 1997.

Now, the first State cannot participate in a reformed health care system until January of 1996. Now, I look at that kind of time lag and I say I think that spells trouble for the inner city hospitals—I have significant inner city hospitals, rural hospitals, and the like—because you are not coordinating these huge cuts with, in effect, phasing in universal coverage for the uninsured?

Now, Penny-Kasich, of course, makes that even worse. But what is your answer about how we make sure that this is all coordinated so we do not make it even tougher for these inner-city hospitals, rural hospitals, the kind of places affected by disproportionate share, indirect costs, these kinds of things?

Mr. VLADECK. Again, I think we have a pretty good mechanism on the disproportionate share and the somewhat less elegant measure on the indirect medical education. But your point is well taken, and part of it is just the complexity of estimating and scoring and getting numbers right in a presentable sort of way. Particularly because, as you know, some of our payment policies are subject to annual update or annual revision on the first day of the Federal fiscal year, some on January 1 of the year, some on July 1, and some, like the hospital, update traditionally on a rolling date in the course of a year depending on the institution's fiscal year. So the exact time when a change has an effective date is not always simultaneous with the Federal fiscal year.

At the same time, you assume most States will implement their programs on January 1 of whatever year of their implementing, but, theoretically, some could do it July 1, April 1, or October 1, and there is no way to set up budget tables or budget scoring to keep track because we do not know exactly the schedule on which the States will come in without sort of adding an incredible layer of complexity.

In general, we are talking about a risk of their being a lag of 3 to 6 months at most on some of these phase-ins. And, again, as I suggested earlier, we would be happy to talk to you about specific changes that would more closely align the timing of the cuts with the phasing in of particular States.

Mr. WYDEN. If you look at one other issue on this round, why is the administration proposing eliminating the Medicare peer review organizations before the quality improvement mechanisms are up and running? It seems to me that there has been an effort for a lot of years to try to get some quality assurance protection. Certainly the senior groups have fought for this, and it seems to me we are getting rid of those before, again, what the administration wants to do in terms of quality improvement is put in place?

Mr. VLADECK. This is at least one instance, sir, in which when you say the administration, I am not sure we are quite as unified and monolithic as the question implies.

Mr. WYDEN. Let us ask you as a person, do you disagree with the policy of getting rid of Medicaid peer review organizations before these other quality improvement mechanisms are in place?

Mr. VLADECK. Yes, I agree with the policy that is stated in our September 7 policy book, and I still am under the impression that the change in the draft legislation may have been the result of an error or mistake somewhere in the process. We are still trying to clear that up.

Mr. WYDEN. So it may not be the policy of the administration to eliminate these organizations before quality improvements are in place?

Mr. VLADECK. That is true. We are trying to clarify what that policy is.

Mr. WYDEN. I hope it is clarified on the side of the senior citizens' right to good quality services and that not be eliminated.

Last question, if I might. To the senior citizen that I talked about earlier who has to go to a legal aid lawyer or one of these private firms to sort through their Medicare bills, what is in this reform proposal to make Medicare more user-friendly to the senior citizens? If you were talking to senior citizens of the country, what is in the proposal to make this an easier system to navigate?

Mr. VLADECK. There are two specific things and then I think we have the opportunity to do some further. Most important, is the elimination of balance billing. That will by itself reduce very significantly the amount of paperwork in the system, the amount of confusion associated with it, all of the problems we now have with the confusion and complexity of implementing limiting charge legislation and so forth. That will make an enormous difference.

Second, we are trying to regularize and rationalize the problem of marketing of medigap coverage and establishing a uniform open enrollment period, some control over the marketing process of that and so forth, which we think would also have an effect.

As we do that, while we have not sought a particular statutory authority, we are going to be working very hard to try to significantly better integrate the processing in Medicare claims with the processing of medigap claims so that process becomes significantly more seamless from the beneficiary's point of view.

If we do those three things together, we will be halfway there towards reducing the hassle factor for beneficiaries, and we will have separate proposals to you in the next 6 months or so to work on the other half.

Mr. WYDEN. What will you do about these high-tech sweatshops that we found this summer that process 400 claims a day every 72 seconds, 8 hours a day, and end up on the medical necessity judgments reversing two out of three?

Mr. VLADECK. As you know, sir, one of the issues associated with that is that our contractor budget has always under the budget enforcement act and under Gramm-Rudman before then been part of capped discretionary expenditures whereas we can prove, and GAO keeps proving for us, that additional investments we make in some of the contractor activities, say the trust funds, which are uncapped

entitlements, several times as much as we spend on the administrative costs.

We are talking as part of reinventing government and in some other contexts about the ability of investing more money in those activities in order to generate trust fund savings and that is very much on our agenda at the moment.

Mr. WYDEN. I appreciate that, because I think what you are really saying is not all administrative costs are created equal and there are some areas like these carrier problems that we are going to actually have to do more. I mean, the idea that people make judgments about medical necessity with no medical training and processing claims every 72 seconds is not, I think, what the American people want, and I appreciate your answer on that point.

Thank you, Mr. Chairman.

Mr. KREIDLER. Thank you. I would like to turn to the gentleman from Pennsylvania, Mr. Greenwood.

Mr. GREENWOOD. That you, Mr. Chairman.

I want to go back to the Penny-Kasich issue for a moment. There has been a lot of discussion this morning about how such a plan would be bad for our beneficiaries. Could you describe the beneficiary in terms of income and then describe the service that that beneficiary would have to pay more for? Would you describe for us the constituent that we need to worry about?

Mr. VLADECK. Well, as I understand the Penny-Kasich proposals, and I may not understand them as fully as I can because they seem to have evolved over the course of the last week, but I will start with the one that is furthest from our proposals, the income relating of the part A deductible, which would affect every beneficiary, I think above that $70,000 ceiling.

Mr. GREENWOOD. So the first person victimized by the Penny-Kasich has an income of at least $70,000?

Mr. VLADECK. In that instance.

Mr. GREENWOOD. And what is the benefit lost to that individual with an income of $70,000 per year?

Mr. VLADECK. What is probably happening is a transfer to that person's medigap policy of the increase in the deductible associated with that proposal, which, over time, means that people who use hospitalization and have higher incomes are increasingly a poor risk for medigap, poor risk for medigap carriers, than folks who have the same incomes and do not use hospitalization.

Mr. GREENWOOD. Do you have any idea what percentage of the social security beneficiaries in this country have incomes in excess of $70,000 per year?

Mr. VLADECK. I don't know that offhand.

Mr. GREENWOOD. I am informed by my colleague that it is less than 1 percent.

Mr. VLADECK. That is inconsistent with our numbers on the $90,000 cutoff in our more modest part B premium proposals, so we would have to find that out.

Mr. GREENWOOD. What do you think it is?

Mr. VLADECK. Less than 10 percent, but I don't know what the exact number is.

Mr. GREENWOOD. Under the President's plan, Medicare beneficiaries who remain in the work force would be treated as employ-

ees and their coverage would be provided through the health alliance, not through Medicare. These older workers and their spouses would be offered the same package of benefits as workers under the age of 65. However, it is unclear how premiums for older workers will be calculated.

To what extent will these individuals be responsible for the employee's share of the premium?

Mr. VLADECK. Well, the employee's share of the premium that is associated with part A benefits, Medicare would pay as a secondary payer. The employee's share of the premium associated with part B-related benefits, to the extent the individual continues to pay their part B premium, Medicare as a secondary payer would pay as well.

The total premium to the individual employer plus employee share that would be paid on the individual's behalf if they are still in the work force would be the community rated premium of all workers for that employer, which one would presume would be substantially less than the Medicare cost if the person was in the Medicare program, on average.

Mr. GREENWOOD. Let me ask you to make this judgment, then. Compare that effect on Medicare beneficiaries to what we just described in Penny-Kasich. How many beneficiaries, or what portion of eligible beneficiaries are having to expend more dollars from their own pockets? Which do you think is going to total up to the greatest number of beneficiaries making new expenditures?

Mr. VLADECK. I think you misunderstand our proposal. First of all, the proposal for Medicare workers in the President's plan is very close to current law. It is not a very significant change at all in terms of existing Medicare secondary payer law.

Second, we think one reason to do this is that the Medicare beneficiary is better off from a financial point of view staying in the employer plan with the employer and Medicare paying all the premium than they would be either in the private insurance market or under Medicare. So they are better off rather than worse off.

Mr. GREENWOOD. So your position is that these individuals will not be responsible for a greater portion of their health care costs under the President's plan?

Mr. VLADECK. That is absolutely correct; they will be responsible for a smaller proportion.

Mr. GREENWOOD. Very well. The proposal also raises questions about beneficiaries who are currently working. Will Medicare beneficiaries who are currently working lose their Medicare coverage under the President's plan?

Mr. VLADECK. I don't believe so.

Mr. GREENWOOD. What happens to older workers when they retire? Do they have the option of remaining in the alliance plan or are they automatically covered under Medicare?

Mr. VLADECK. They have the option of remaining in the alliance plan if the alliance plan has a contract with us.

Mr. GREENWOOD. Many older workers are employed periodically throughout the year. How many individuals who are periodically employed and unemployed will be covered? Will they be required to shift their Medicare to an alliance plan based on their employment status?

Mr. VLADECK. No, if they meet the minimum threshold for requirement, which I believe is 40 hours a month for one quarter, whatever the minimum threshold is for employment-related coverage, they will maintain that coverage for the balance of the calendar year. It is 40 hours a month for 2 months. If they work that much, they are entitled to employer-related coverage and then they will remain in the same plan for the balance of the calendar year, as would be the case of part-time workers over any age.

Mr. GREENWOOD. The President's plan permits all individuals enrolled in managed care plans through an alliance to elect to either remain in the alliance or under the Medicare program when they turn 65. However, the choice to remain in the alliance would be limited only to those individuals enrolled in managed care.

This provision raises several questions: Has the administration given any consideration to the fact that those who remain in the alliance are likely to be healthier as a result of being younger than the remaining Medicare population? Do you think a risk adjusted payment method is needed to assure that the actuarial base of Medicare is maintained?

Mr. VLADECK. As I answered Mr. Brown earlier, sir, to the same question, and I can even provide the same answer, we have to refine our payment method so that there is an appropriate—there is an actuarial risk adjustment now but it is not sufficiently refined, and unless we further refine it, there would be that risk of selection against us in the program.

We think we know how to make that refinement and we will do it prior to implementation of these provisions.

Mr. GREENWOOD. I apologize if I missed that. I must have been voting. What premium would a 65-year-old who elects to remain in the alliance managed care plan pay?

Mr. VLADECK. A 65-year-old who is no longer working, what they would pay, as is now the case, would vary enormously based on what the plan is able to provide in terms of its benefit package relative to what the Medicare appropriately actuarially adjusted risk of payment is.

Let me tell you a little more what I mean about that. Currently, in our risk contract plans, those plans for the Medicare beneficiary, without additional premiums, offer anywhere along the range from just the basic Medicare benefit all the way up through a benefit package with no coinsurance, no deductibles and a reasonably good partial drug benefit, because those plans are able to provide the basic benefits sufficiently far below our payment rates to provide the additional benefits.

We would anticipate continuing to see the same range in what those plans would offer, over and above the basic package for, whether they are getting paid for by Medicare, plus a relatively modest individual monthly premium.

Mr. GREENWOOD. This is a long question. The plan requires the Secretary of HHS to project a hospital-specific per admission relative value for the next year by October 1, beginning in 1997, for each hospital, and to estimate whether this hospital-specific projected value will exceed the allowable average per admission relative value applicable to the hospital.

If any overage is projected, the Secretary would reduce all payments made for hospital inpatient services provided by physicians on the medical staff by 15 percent. Actual and projected shortfalls would not be reconciled until October of the following year. Where the actual average per admission relative value did not exceed the allowable per admission relative value, the Secretary would reimburse the medical staff for the amount by which payments were reduced.

However, where the limit was exceeded, but by less than 15 percent, the medical staff would not recoup the full amount by which its overage was less than 15 percent. For example, if the limit was exceeded by less than 10 percent, the Secretary would reimburse the medical staff for the difference between 10 percent and the actual percent by which the limit was exceeded. If the limit was exceeded by more than 10 percent but less than 15 percent, none of that withheld would be returned.

What is the rationale for not fully reimbursing medical staffs for the amount by which its overage was less than 15 percent?

Mr. VLADECK. Somebody made a mistake. That is the rationale, and that will be fixed. That was a drafting error. I think this entire proposal, which is in there and has some very good strengths to it, is still at the early stages and needs to be refined.

As the folks from the Physician Payment Commission can tell you, we continue to have these large unexplained variations in intensity of medical services or use of medical services that we cannot explain from one community to the next, and as we have greater equity in the fee schedule some of those sore thumbs stick out more deliberately than they have in the past.

This proposal is an attempt to begin to address that issue of not returning 100 cents on the dollar. It is just an error in drafting, but as your reading suggests, it is probably a somewhat more complicated way of getting at this than we would ultimately desire. We have this here as an indication that we want to do something about this problem, and we think there are ways available but we would like very much to work with you to find a simpler and more direct way of addressing this issue.

Mr. GREENWOOD. With the Chair's indulgence, I would ask two things: One, that Mr. Vladeck provide for the record the percentage of the Medicare population who exceed that $70,000 income figure.

Mr. VLADECK. Absolutely.

Mr. GREENWOOD.Hopefully before the vote, in any case.

And, second, I would ask when you might submit to us the refinement of the error that you just acknowledged?

Mr. VLADECK. Again, that error is a technical drafting error and, I believe, will be corrected between the draft bill and the submission, the formal introduction of the bill within the next couple of days. If it is not, we will——

Mr. GREENWOOD. When is the formal introduction of the bill?

Mr. VLADECK. Within the next couple of days, as I understand it.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. KREIDLER. Gentleman from——

Mr. HASTERT. Mr. Chairman, can I just ask a question?

Mr. KREIDLER. Sure.

Mr. HASTERT. Did you say you will have the bill here in the next couple of days?

Mr. VLADECK. That is my understanding, sir.

Mr. HASTERT. That was our understanding 4 weeks ago.

Mr. VLADECK. Well, it is still true.

Mr. HASTERT. Is that an absolute guarantee; we will have the bill in a couple of days?

Mr. VLADECK. I understand you gentleman are hoping to adjourn in a few more days, so I am hopeful it will be here before you do. I am certain of that. That is just a few more days beyond a couple of days.

Mr. HASTERT. Thank you, Mr. Chairman.

Mr. KREIDLER. Thank you.

The Chair recognizes the gentleman from New Jersey, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to say originally, Mr. Vladeck, that I basically support the President's plan, at least today, but I am very concerned about the effect on seniors because there are so many seniors in New Jersey, and particularly in my district, and I know it has already been mentioned or I think it has already been mentioned, but the concern essentially is about the trade-off with cuts in the Medicare program versus the expanded programs for long-term care as well as prescription drugs.

The fear, I guess, is that you know, with the cuts, what is that going to mean; and, on the other hand, with long-term care and with prescription drugs, two things; that the long-term care promise would not be met because essentially, as you mentioned, it is not part of Medicare: It is something worked out with the States? And will the money necessarily be there? Will it vary depending on the situation from State to State?

New Jersey, for example, has a terrible budget crisis. I don't think it is going to get any better in the next year. Is there going to be a situation where some of the promise in terms of covering some of these services has to be passed on to the States and ultimately is not provided?

And with regard to the prescription drugs, again that may depend on the different States and how they treat it. In New Jersey, we have a prescription drug program for lower income seniors that is funded through casino revenue funds. But the fear is will I have any premium go up, am I going to get as much back in terms of the coverage because of the deductible? I know that is a lot, but this is the concern and I just wanted you to address that, if you could.

Mr. VLADECK. I am happy to try to because I think they are real and appropriate concerns.

Let me first say that I think, on the prescription side, it will be a national program. It will be implemented relatively early in the total timetable of implementation. And as opposed to that which was anticipated, I think, unfortunately, under catastrophic, beneficiaries will begin to be able to see some of the benefits associated with the expanded benefit before the full effect of the savings changes take effect. That is certainly our intention.

But let me say more generally it is a difficult argument to make, and one that with particular audiences takes some explaining to do, but I think has to be made, and it is essentially the argument we are making, and that is if we do nothing, the Medicare program is going to be eroded significantly in the years to come anyway. It is going to be eroded primarily because, first, unless we do something about health care costs in general, either Medicare outlays will grow faster than we can afford and the trust funds will be able to afford, or we will have to continue to cut back what Medicare is paying relative to what the private sector is paying, increasing these differentials and creating access problems, or, more likely, both.

Mr. PALLONE. Let me get to the specifics, though. As far as the prescription drug program, and you have done some calculations in terms of how much seniors put out in a given year for prescription drugs, the premium goes up under the program, but you have a $250 deductible. What kind of statistics are there to show the additional cost versus how many seniors would go over the deductible in terms of the amount of drugs that they would use in a given year?

Mr. VLADECK. I don't—wait, I do have the numbers here. No, I don't have the numbers he wants, though.

I think our estimate was that about 60 percent of Medicare beneficiaries would actually exceed their drug deductible in the course of a given year and actually receive some very specific benefits from this new benefit. Many of them will exceed it by a very substantial amount.

Mr. PALLONE. Would States like New Jersey, that have a separately funded program for low-income seniors, they only pay I think, I don't know, $5. They pay $5 now. For example, every time they have to get a prescription, would they be able to continue those kinds of programs with separate funding?

Mr. VLADECK. Again, I would encourage States to do that in the form of essentially a wraparound, a program in which for low-income seniors and given the dollars available you could probably raise that threshold substantially and the States would pay part of the deductible or all of the deductible for low-income persons and maybe even buy down some of the coinsurance as well.

Mr. PALLONE. OK, that is an important point.

Mr. VLADECK. To the extent those pools of money are still available under health care reform, that would be a good way to use them.

Mr. PALLONE. What about the long-term care? I know you were not coming here today to address that, but it seems to me somewhat obscure about what kind of State participation there has to be. I understand it is a Federal program, but I think—are there going to be circumstances where States would have to pay for part of that funding?

Mr. VLADECK. Let me try.

Mr. PALLONE. Would it vary in terms of what is provided depending on what the States pay?

Mr. VLADECK. Let me try to clarify that, if I can. It is really a State program with largely Federal funding in the sense it is very much a State-administered and State-managed, State-tailored pro-

gram because of the variation in needs from State to State and the amount of stuff States are already doing on long-term care as well.

The big financial issue here is that the matching rate for State and Federal contributions is the Medicaid rate plus 20 percent with a floor. So that the incentives from the State's point of view to participate as fully as possible in the system are quite attractive.

Mr. PALLONE. Then, in other words, you could have some States providing more for less services for long-term care.

Mr. VLADECK. We would expect that every State will seek to, since the amount of Federal money that is available under the program is capped, we would expect the States almost invariably to drawdown the maximum number of Federal dollars they could and then some States, depending on the economy and other phenomena, might well go above that many as well. Many States are now putting substantial amounts of their own dollars into community-based long-term care services of one sort or another.

Mr. PALLONE. You mentioned today or I think it is in your testimony about copayments for home health care visits. That bothered me somewhat, because the whole idea it seems is to try to expand long-term care, cut down on institutional care, hospital care, whatever. A little concern about the copayment for that, knowing the way seniors operate. I understand the President wants people to have a certain amount of responsibility. I am wondering why that was put in.

Mr. VLADECK. There is another issue, sir. There are two reasons why that was put in, in essence, the first of which, frankly, is that our home health care outlays under Medicare part A have been growing at a compound rate of 30 percent or more a year for the last several years and we have to do something about that. But the more rational, as it were, the bigger picture argument, is the following:

The Medicare home care benefit is not supposed to be a long-term care benefit, it is supposed to a post acute benefit for people emerging from a hospital in need of a limited amount of home care at the conclusion of an episode of illness.

It has evolved, to a considerable extent, into a long-term care or chronic care benefit because of the absence of alternatives for many folks, even though it is too medically intensive, it is too high-tech and too expensive to make sense as a long-term care program.

But in the absence of other long-term care programs, Medicare, which should not be, under the basic—under the initial legislative intent is paying for more and more long-term home care.

What the coinsurance proposal we have made, we have said we will not impose the coinsurance during the first 30 days of home care following discharge from a hospital, which is what the Medicare benefit is supposed to be for, but we are going to begin to try to discourage its use as a long-term care benefit while, at the same time, we are developing a new expanded long-term care benefit.

Mr. PALLONE. I see. I understand what you are saying. So one does not necessarily have anything to do with the other. You may not have the copayment for your other long-term service.

Mr. VLADECK. There will be copayments on an entirely other basis for the long-term care but no copayment for the acute part

of Medicare home care. That is the important part under our proposal.

Mr. PALLONE. OK. I don't know again if it was mentioned, but increasingly what we find is a lot of doctors simply do not accept Medicare assignment, and that is a concern particularly with the additional cuts. How do you expect to address that?

Mr. VLADECK. Again, we are going to, through the elimination of balance billing, basically require what is, in effect, assignment for physician payment under this proposal.

Mr. PALLONE. Maybe I missed that. Explain to me how that works.

Mr. VLADECK. Well, the physicians who do not accept assignment generally do it for a variety of reasons. They wish to bill whatever they want, collect what Medicare will pay under the fee schedule, and collect—we assume every physician only wants to do what is within the letter of the law—the additional 15 percent above the fee schedule for the beneficiary that is now permissible.

We are not going to—under our proposal, that additional 15 percent balance billing will not be permitted. They will have to take the Medicare payment as payment in full. There is no reason not to accept assignment at that point.

Mr. PALLONE. OK. Thank you.

Mr. BROWN [presiding]. The gentleman's time has expired.

The gentleman from Illinois, Mr. Hastert.

Mr. HASTERT. Couple of things I want to talk about. First of all, a quick question. A lot of the new benefits that are developed in your health care program are funded using the rearrangement of DSH money, disproportionate share money. You say that you can do that because real savings and realized by moving these people into other enterprise areas of health care.

What about children's hospitals? Those hospitals who have the sickest of the sick kids; kids on ventilators. Will that DSH money still be there? How are you going to deal with those situations?

Mr. VLADECK. Again, most DSH money will go to compensate individuals for caring for uninsured folks. That is as true of the children's hospitals as it is for other recipients of DSH payments.

Mr. HASTERT. You know, if you have a kid with spina bifida, it is kind of hard to get insurance.

Mr. VLADECK. Under the President's proposal, whether your kid has spina bifida, leukemia, or any other problem, you will be entitled to health insurance. The hospitals that provide your kids with care will be treating an insured patient.

Mr. HASTERT. But those people will be, those kids will be concentrated in two or three hospitals per city or spread out.

Mr. VLADECK. We hope so, because we think that kind of concentration and specialization produces better quality of service.

Mr. HASTERT. So there will still be a disproportionate share; am I not correct?

Mr. VLADECK. Not in the way we have used it in terms of a disproportionate share of low income.

Mr. HASTERT. So you have redefined disproportionate share?

Mr. VLADECK. No, we are sticking with the existing definition. But I will say the President's proposal requires every health insurance plan to contract with specialty providers for specialty services

of that sort to make sure that those institutions continue to serve those kids and are paid appropriately for it.

Mr. HASTERT. Utilization. We have been talking about utilization here. We had a couple of gentlemen from the administration who, quite frankly, threw up their hands and said we don't know what the utilization is going to be.

Are you sure what your utilization is going to be in these new programs for instance, the drug program under Medicare and the 55 retirement program, do you know what that utilization is going to be? Do you have hard numbers on that?

Mr. VLADECK. We do not know for a fact, of course, with something that has not occurred before. There are analogies. We know what Medicare beneficiaries are now getting their prescription drugs. But as you may have seen reference to, there is a very widespread perception in the health policy community in Washington that the HCFA actuary is very conservative in its estimates of utilization effects, and those are his estimates that we are using.

Mr. HASTERT. I want to walk through a scenario, and I think that is the concern we all have—and, Mr. Chairman, I ask unanimous consent to distribute a chart which I will be referring to.

Mr. BROWN. Without objection, so ordered.

Mr. HASTERT. The Clinton health care plan entitles all Americans to health care coverage. As we talked about, for many of those who are currently uninsured, the working poor and employees of small businesses, the plan helps to pay for that coverage through subsidies. The plan also expands Medicare benefits with the addition of a prescription drug benefit and a long-term care benefit, which we just talked about, and, at the same time, realizes draconian cuts in the growth of the Medicare and Medicaid programs.

I would like to explore with you the ability of the Congressional Budget Office and the executive branch agencies, OMB and the HCFA's Office of the Actuary, to score new Federal entitlements and benefit expansions. To demonstrate the difficulty in scoring, I will use an example with which the Congress has become recently familiar, at least those of us who have been here before 1988, and that is the passage and repeal of the Medicare Catastrophic Coverage Act. Let us walk through this chart to see what the actual CBO estimates for catastrophic were.

While the estimates for two of the benefits were relatively close at passage and repeal, the estimates for the prescription drug benefit and the skilled nursing facility, these things we have just talked about in this room a minute ago, demonstrate the potential for tremendously inaccurate estimates.

The prescription drug benefit was estimated to cost $5.7 billion in June 1988, which was the estimate used when catastrophic was passed. Just one year later, before the benefit was even implemented, the estimate jumped $6.1 billion to $11.8 billion when it was repealed.

The estimates for the skilled nursing benefit, which are even more disturbing, the June 1988 estimate, which again represents the estimate at passage, was a paltry $2.1 billion. The CBO reestimate in August of 1989 was an astounding $13.5 billion, an increase of 643 percent.

What occurred is that the Congress unintentionally created a new entitlement for long-term care which covered individuals for 150 days per year. The legislation eliminated the prior hospitalization requirement, increased the maximum stay from 100 days during a spell of illness to 150 days annually, and dramatically reduced the beneficiary copayments.

Therefore, 1 year after enactment of the act, the combined estimates for these two benefits grew a whopping $18.2 billion.

Mr. Vladeck, when it comes to the budget, health care entitlements and estimates have always been and always will be an unforeseen consequence. However, there is one area where we can all agree, that estimates as to the cost of benefits will always be too low and estimates of savings will always be too high.

Sir, how confident are you in the administration's assumptions and numbers that we will not be faced with the same extent of miscalculation in estimating the cost of the Clinton health plan entitlements for Medicare prescription and drug benefits and the preretiree health care benefit, the long-term care benefit and the entitlement which will provide insurance coverage to the 37 million uninsured Americans that we have today?

Mr. VLADECK. Sir, I think in order to answer your program correctly—question correctly——

Mr. HASTERT. Just a question, not a program.

Mr. VLADECK [continuing]. Puts me in a somewhat embarrassing situation because—at least awkward situation—because the estimates in your chart are CBO estimates, and if I understand it correctly, relative to catastrophic, the track record of HCFA's actuary was substantially better.

Mr. HASTERT. The President said he would go by CBO.

Mr. VLADECK. No, I believe your rules require CBO estimates in terms of the evaluations of some of these things. Our proposals are based on our estimates.

I think it is also true to say we have not always been right, either.

Mr. HASTERT. I will tell you we are playing by the rules the President set. The President said he would use CBO numbers.

Mr. VLADECK. We will try to work with CBO to see that they get to be as good as we are.

Mr. HASTERT. All right. Continue.

Mr. VLADECK. I think, the other issue is we have erred in the past, too, certainly. We overestimated by a significant amount the behavioral effect of the Medicare fee schedule, for example, and, thus, significantly overestimated the potential cost of the movement from the previous system to Medicare fees, and set physician fees too low as a result because of that overestimation.

So I don't think it is true that historically all the estimates are always too low. Sometimes we do guess too high. I do think that what we have tried to do in terms of the proposal on the drug benefit and some of the other more sensitive parts of the President's plan is to build a significant amount of caution and conservatism in those estimates which are now being described as a cushion that is available for deficit reduction.

Mr. HASTERT. So you disagree, then, with Secretary Reich and Secretary Bentsen when they said that they cannot even begin to guess what the utilization of these programs would be?

Mr. VLADECK. If I am not mistaken, however, they also said they believe the estimates of the cost of these programs were sufficiently conservative to account for any likely range of utilization.

Mr. HASTERT. When will we receive the data behind these numbers?

Mr. VLADECK. Having had quoted before in this session comments made by my superiors in the administration about dates that have not entirely been met, I am certainly not going to go out on a limb. As soon as we can get them to you.

Mr. HASTERT. But after we get the bill someday; right?

Mr. VLADECK. I suspect that is true.

Mr. HASTERT. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hastert. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Vladeck, hitchhiking on a question asked by Mr. Greenwood regarding the President's plan permitting all individuals enrolled in managed care plans through an alliance to elect to either remain in the alliance or enter the Medicare program when they turn 65, the choice to remain in the alliance would be limited only to those individuals enrolled in managed care; is that correct?

Mr. VLADECK. That is correct, sir.

Mr. BILIRAKIS. That is correct. What is the reason for that? Why can't that individual enroll in a fee-for-service plan, for instance? Is it an individual—forgive me, I didn't mean to really interrupt you when you started to answer. But are we saying if an individual is working and is in a plan, the plan that that person is enrolled in under the alliance is a fee-for-service plan, and then a person chooses to retire and remain in the alliance, he is limited to a managed care plan only?

Mr. VLADECK. If he wants to remain in the alliance, he is certainly entitled to fee-for-service coverage under Medicare.

Mr. BILIRAKIS. Under Medicare?

Mr. VLADECK. Yes, sir.

Mr. BILIRAKIS. But not under the alliance fee-for-service plan?

Mr. VLADECK. That is right.

Mr. BILIRAKIS. He is limited, then, if he wants to recommend a plan in the alliance. He is limited strictly—even though he has been for years maybe a member of a fee-for-service plan under the alliance, he is limited only to a managed care plan?

Mr. VLADECK. Yes, sir. And I guess I would explain that or comment on that by I guess—I don't know if this is appropriate answering a question with a question, which is that we do not understand why the individual, if they wish to remain in a fee-for-service plan, would want to remain in the alliance once they become eligible for Medicare. Since we do not think the private sector plans will be able to compete with us on administrative costs, we do not know what they would be offering on a fee-for-service plan that Medicare does not already offer the beneficiary.

Mr. BILIRAKIS. But do you think they might choose to remain in the alliance in a managed care plan?

Mr. VLADECK. To the extent that they have a defined provider relationship, that they have a doctor, for example, who only practices within the managed care plan, and they want to continue to have that doctor, then we would expect they would want to continue with that plan.

Mr. BILIRAKIS. Well, I guess I sort of expected maybe part of the answer to go to the supposed $124 billion Medicare savings as forecast by the Clinton administration. Maybe I can get into that.

If it has been asked, I don't want to be redundant, sir. I don't want to put you through it again. But if the Medicare savings of $124 billion, I came at the tail end, again forgive me for coming in late but I had a hospital and health care hearing on Veterans Administration, we manage to do these things all at the same time up here, but Mr. McMillan had just finished up going into the $56 billion, $57 billion Medicare cuts in the President's budget reconciliation package, which I did not support.

But let's go to the $124 billion. How do we account for that $124 billion? That is my question. And if you have already answered it and it is in the record, I will just withdraw it.

Mr. VLADECK. Let me just repeat very, very quickly. Of that money, about just under half is reduction in the rate of increase in payments to hospitals over the 1996 through 2000 period. About 20 percent are reductions in the rate of increase of physician payments. There are reductions in rate of increase in payments to skilled nursing facilities and home health agencies as well. And, in addition, the imposition of a copayment on laboratory services and the copayments I was just talking about with Mr. Pallone on home health services.

There is, in the savings, about $8 billion in increased premium revenues from State and local employees, that group of State and local employees who are not now paying the HI payroll tax, and some other changes in premium-related issues for beneficiaries that account for most of the rest of it. But the biggest pieces are again rate of growth and particular payment provisions for hospitals, physicians, skilled nursing facilities, home health agencies and then the coinsurance on the labs and home health.

Mr. BILIRAKIS. Are we sort of thinking here that by continual cuts in reimbursements to hospitals and other providers that it will drive—it is already happening, so I feel free in saying—will drive many of them out of Medicare practice?

I don't know how much it will reduce the benefits that are available to them. Certainly it will probably affect the quality of health care they provide. We cannot keep cutting and cutting and cutting and expect it to remain the same, although we all know there is a lot of fat and waste in the system.

But are we figuring that more and more people will choose against Medicare as a result of all this happening and will maybe stay in an alliance plan or go into an alliance plan and, therefore, that is going to result in less cost as far as Medicare is concerned?

Mr. VLADECK. No, sir. And, again, your question gives me the opportunity to repeat, which I am glad to do, the comment that we would defend the Medicare savings proposals that we have made only in the context of an overall health care reform plan, which

provides for even more significant reductions in the rate of growth of spending in the private sector.

So we can defend these Medicare provider payment reductions only to the extent they are happening in the context of reductions in revenue flowing to providers in the private sector, which we think over time will ameliorate, not worsen, the issue of differential access for Medicare beneficiaries as opposed to other folks.

Mr. BILIRAKIS. Well, we, as elected officials, sir, receive many communications from our constituents regarding various issues. I still have not recovered from the last few days. But as far as Medicare is concerned, our seniors are very concerned, very upset. They can just not see it not adversely affecting them over a period of time.

Does your office receive the same sort of thing?

Mr. VLADECK. Yes, we do.

Mr. BILIRAKIS. You do. Any comments as to what those communications are reflecting?

Mr. VLADECK. Well, I think there is—I think we get a lot of mail from our beneficiaries on a lot of issues, and some of them are more short-term than these, but there is a lot of anxiety and a lot of concern among the folks we talk to about the issue of the extent to which they are going to continue to have access to the providers of their choice and to the type and quality of providers.

And the answer has to be that Medicare's further reductions in the rate of growth of Medicare provider payments can only go forward in the context of system-wide cost containment, otherwise there may well be an access problem for beneficiaries.

Mr. BILIRAKIS. Yes. All right, thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bilirakis.

Mr. Vladeck, I would like to ask you to comment on several of the specific saving items of the President's bill.

First, I strongly support your intention to deal with the high cost sharing borne by Medicare beneficiaries when they receive hospital outpatient services. Because these coinsurance amounts are based on hospital charges, not Medicare payment amounts, the beneficiaries' out-of-pocket shares have been rising rapidly. They are now routinely paying considerably more than 20 percent of the Medicare payments for these services which is not what the law intends.

I thought you wanted to lower these out-of-pocket payments so that they would eventually equal 20 percent of the Medicare-approved amount. But if I read your testimony correctly, it looks like there will only be a cut in the Medicare payment, not a cut in what the beneficiary is expected to pay for these services. Is my reading accurate? Is there no better way to fix this problem so that beneficiaries get the protection intended by law?

Mr. VLADECK. Your reading is accurate, sir. We had, at another point in the hearing, promised the members that our long overdue report to the Congress on outpatient payments will be emerging in the reasonably near future, and that will contain specific recommendations for moving forward on this issue in the context of broader reform of Medicare outpatient payment.

We have not incorporated those recommendations along with these proposals for a variety of reasons, including the basic budgetary reasons, but we will be bringing that issue back to you separately in such a report in the next few months.

Mr. WAXMAN. Thank you. Another item I want clarified is the proposal to limit payments for medical staffs of hospitals that have high levels of physician services. You testified that there are large differences in the amount of physician services provided to patients admitted to hospitals. In the same DRG category, you have concluded that much of this variation is the result of differences in the way physicians practice.

As I understand it, under this proposal a portion of the expected physician payments to physicians in those hospitals with relatively high levels of physician services would be withheld at the beginning of the year than at the end of the year depending on actual performance. Some or all of the withholding would be returned to an organization representing the medical staff of a hospital.

This sounds like a very complicated scheme to me and one that will be hard to administer. More important, I don't see how this policy can be applied fairly given the loose structure of hospital staffs and the multiple hospitals in which many physicians practice. Could you help us understand this better? At first glance, it looks pretty arbitrary to me.

Mr. VLADECK. Well, I will try on the understanding it is a complicated proposal and one that would be difficult to administer. There is a very real problem out there in terms of what might be described as hot spots of very high physician utilization, given the kind of illness they are treating, and at the moment this is the best specific notion we have of what to do about it. But we are working to try to refine that proposal to look at other ways that might be more direct and less complicated of addressing that problem. And as we work with you on this legislation over the coming months, I hope we are able to substantially simplify and make more targeted and direct that proposal.

Mr. WAXMAN. Finally, let me ask you about the changes in payments for primary care services that are included in the President's package. We will have testimony later today from the PPRC and a number of physician organizations arguing that these reductions in the relative values of certain physician services in order to increase the relative values of primary care services violate the core principle of the Medicare fee schedule that payments should be based on the resource cost of services.

How do you respond to these and other critics, many of whom share with you the desire to increase compensation for primary care services? Are there other ways that we can encourage the provision of primary care services without undermining the credibility of the fee schedule that we worked so hard to put in place? And what about some kind of adjustment that does not disturb the established relative value scale?

Mr. VLADECK. The core principle of the relative value scale to which we remained very much committed is, as you know, Mr. Chairman, embedded in a whole number of layers of phase-in and other kinds of adjustments as we move forward with the implementation of this. It is not possible, even consistent with that philoso-

phy, to entirely eliminate matters of policy judgment from a physician fee setting.

We have always operated the system under the notion that any adjustment of one sort must be budget neutral in the aggregate. We think most of the changes we are proposing to try to benefit primary care are within a reasonable range of judgment, given some of the complexities and some of the phase-in and timing issues associated with implementation of the system.

Mr. WAXMAN. I have one last question. What happens to people when they become eligible for Medicare under the President's plan? As I understand it, if they continue to work they will choose their coverage from an alliance like other workers, if they leave the work force they can remain in their alliance plan but only if it is a Medicare HMO, or else they will be in the standard Medicare program with fee-for-service coverage or a Medicare HMO.

Now, what I am having trouble seeing is what in the way of new choices or options this offers Medicare beneficiaries in contrast to what they now have, and am I missing something here?

Mr. VLADECK. No, I think there may be a little lack of clarity on our part. I think most of the new choices that Medicare beneficiaries will have will come in two places: One, from simplification of the process, or trying to make it more automatic for folks who are comfortable within their managed care arrangement and employment to be able to stay in it at retirement. The other is for folks within the Medicare program, we have proposed a number of ways to expand their choices through this open enrollment method, through development of Medicare PPO's and things of that sort.

I made reference to the general principle in my statement, but I guess I did not elaborate on what the components of some of the increased choices will be within the context of the Medicare program itself.

Mr. WAXMAN. Thank you, very much.

Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman.

Let me direct your attention to a chart here that we viewed before in some budget committee hearings. Really, what I want to get at is your degree of confidence in your own forecasts of cost and revenues. As you well know, CBO is required to make a midyear forecast in January of each year as to the economic and budgetary outlook, and these two lines reflect their forecast done in January 1991 and January 1993 for Medicaid and Medicare.

[The following charts were submitted:]

CBO Baseline Projections
For Medicare & Medicaid

(by fiscal year in $billions)

Medicaid

	1992	*1993*	*1994*	*1995*	*1996*	*Totals*
Jan. 1991*	$57	$64	$72	$80	$90	$363 billion
Jan. 1993**	$68	$80	$92	$105	$118	$463 billion
Difference, 1993-1991	+11	+16	+20	+25	+28	$100 billion

$100 billion added to Medicaid CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

Medicare

	1992	*1993*	*1994*	*1995*	*1996*	*Totals*
Jan. 1991*	$127	$140	$156	$173	$194	$790 billion
Jan. 1993**	$129	$146	$167	$188	$211	$841 billion
Difference, 1993-1991	+2	+6	+11	+15	+17	$51 billion

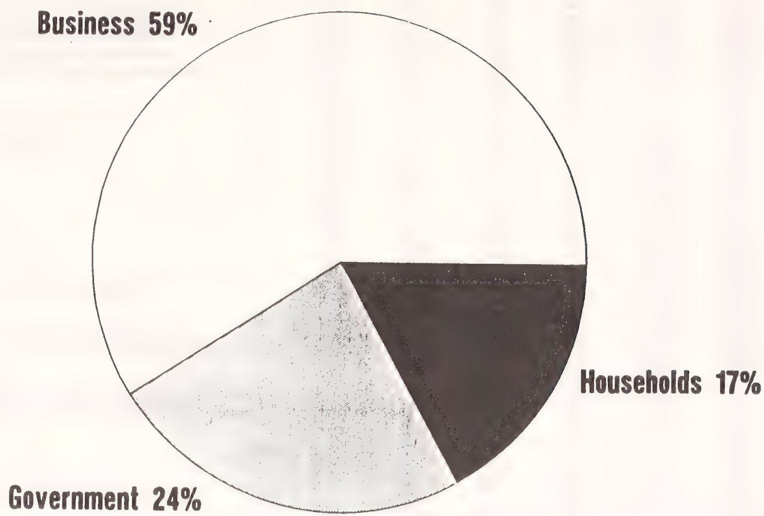
$51 billion added to Medicare CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

The Economic and Budget Outlook: Fiscal Years 1992-1996, January 1991, Congressional Budget Office, p. 91

CHART 1

Source of Revenue for Premiums

Percent of Public and Private Premiums Under Reform



Source: HCFA; Office of the Actuary

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Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
Medicare Savings	2.5	10.0	15.2	23.0	32.4	40.3	123.4
Part A	0.0	4.1	7.4	12.3	16.3	20.2	60.3
Part B	1.6	2.2	3.7	7.1	9.6	10.5	34.7
Parts A and B	0.9	1.9	1.6	1.2	4.1	7.1	16.9
HI Tax Extended to all State & Local Government Employees	0.0	1.5	1.5	1.5	1.4	1.4	7.3
Income Related SMI Premium with outlay and premium effects	0.0	0.4	0.9	0.9	1.0	1.1	4.2
Medicaid Savings	0.0	1.0	3.9	10.4	22.2	27.8	65.3
Savings from Capitation of Cash-Eligible Beneficiaries	0.0	0.3	1.2	3.9	6.7	10.2	22.3
Reduced Disproportionate Share Hospital Payments	0.0	1.4	4.7	13.0	16.8	18.6	54.5
less Offset for Reserve	0.0	-0.2	-0.4	-1.0	-1.0	-1.0	-3.6
Less Wrap-around Benefits (net of offset)	0.0	-0.1	-0.6	-1.5	-1.9	-1.9	-6.0
Payment Lag, Administrative Savings, and Other Changes	0.0	-0.4	-1.0	-4.0	1.5	1.9	-2.0
Tobacco Tax/ Corporate Assessment	12.3	14.9	15.8	15.7	15.5	15.3	89.4
Tobacco Tax	12.3	11.1	10.9	10.6	10.3	10.1	65.3
Corporate Assessment	0.0	3.8	4.9	5.1	5.1	5.2	24.1
Other Federal Savings	0.0	1.0	2.8	10.1	12.2	13.5	39.6
Veterans Affairs (b)	0.0	0.6	1.7	4.3	4.5	4.7	15.8
Defense Department Health (a)	0.0	0.1	0.2	0.7	0.8	0.8	2.6
Federal Employees Health Benefits	0.0	0.0	0.0	3.3	4.5	5.4	13.2
Public Health Service Savings	0.0	0.3	0.9	1.8	2.4	2.6	8.0
Other Revenue Effects	0.1	0.1	6.4	14.5	21.6	25.4	68.1
Effects of Mandate, Cost Containment, and Subsidies	0.0	-0.1	0.7	3.6	8.0	10.8	23.0
Exclusion of Health Insurance from Cafeteria Plans	0.0	0.0	5.0	7.7	8.3	8.9	29.9
Incentives for Health Providers in Shortage Areas	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Anti-Abuse Rule -- Certain S Corp. Shareholders	0.0	0.2	0.5	0.5	0.5	0.5	2.2
Reporting Penalties -- Non-corp. Ind. Contractors	0.1	0.1	0.1	0.1	0.1	0.1	0.5
Modify Tax Treatment of Certain Health Care Orgs.	0.0	0.0	0.1	0.2	0.2	0.2	0.7
Modify Tax Treatment Retirement Funding Accounts	0.0	0.0	0.0	0.1	0.1	0.1	0.3
Assessment on Employers for Retiree Subsidies	0.0	0.0	0.0	2.4	4.4	4.7	11.4
Recapture Retiree Subsidies High-Income Recipients	0.0	0.0	0.0	0.0	0.1	0.1	0.2
Debt Service	0.3	0.6	0.6	0.3	0.6	2.1	4.3
TOTAL	15.1	27.6	44.7	73.9	104.5	124.3	390.1

(a) Under the proposed legislation, the Secretary of Defense is to decide when the military system will be coordinated with national health reform. This table shows the estimated budgetary effects on the Department of Defense if the military system were to be fully coordinated with national health reform by FY 1998.

(b) New receipts to reimburse Veterans' expenses

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Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
Public Health/Administration	3.6	5.3	5.9	5.6	5.3	5.4	31.1
WIC Enhancement	0.0	0.5	0.6	0.6	0.7	0.7	3.1
New Public Health Initiatives	0.4	1.5	2.6	3.3	3.7	3.8	15.3
Net New Spending on Acad. Health Ctrs. and Medical Educ.	0.0	2.2	1.4	-0.1	-0.1	-0.2	3.2
Total Spending	5.9	6.3	6.7	8.0	9.5	9.6	46.0
Less Current Medicare Funding	-5.9	-3.6	-3.6	-3.6	-4.0	-3.9	-24.6
Less Premium Offset	0.0	-0.5	-1.7	-4.5	-5.6	-5.9	-18.2
New Federal Administrative and Start-Up Costs	3.2	1.2	1.3	1.8	1.1	1.1	9.6
Long-Term Care	0.0	5.7	9.3	12.7	16.5	20.6	64.7
Net Home Based Care for the Disabled	0.0	4.5	7.8	11.0	14.7	18.7	56.7
Total Spending	0.0	6.9	11.2	14.7	18.7	23.0	74.5
Medicaid Offset	0.0	-2.4	-3.4	-3.7	-4.0	-4.3	-17.8
Liberalized Medicaid Eligibility	0.0	1.0	1.0	1.0	1.0	1.0	5.0
Tax Incentives for Long-term Care	0.0	0.2	0.5	0.7	0.8	0.9	3.0
Medicare Drug Benefit	0.0	6.6	13.5	14.2	15.2	16.2	65.8
Benefits, Administration, and Pharmacists Costs	0.0	8.2	16.3	17.5	18.7	20.0	80.8
Less Rebate	0.0	-1.6	-2.8	-3.3	-3.5	-3.8	-15.0
100% Tax Deduction for Self-Employed Health Insurance	0.5	0.6	0.9	1.7	2.9	3.1	9.7
Premium Discounts (Subsidies)	0.0	7.3	18.4	47.8	44.4	43.2	161.1
Premium Discounts (Subsidies) -- Net of Cushion	0.0	5.7	13.9	35.6	31.7	30.1	117.0
Capped Entitlement for Premium Discounts	0.0	10.3	28.3	75.6	78.9	81.0	274.1
Total Discounts (Subsidies)	0.0	12.8	35.7	96.3	100.6	103.6	349.0
Employers (net of cushion)	0.0	3.9	10.9	27.9	28.3	28.6	99.6
Non-retired Households (net of cushion)	0.0	6.0	16.7	43.7	45.5	47.3	159.3
Retirees -- low income subsidies (net of cushion)	0.0	0.9	2.6	6.9	7.2	7.4	25.0
Retirees -- added subsidies (net of cushion)	0.0	0.0	0.0	3.0	4.2	4.4	11.6
Out-of-Pocket	0.0	0.3	1.0	2.6	2.7	2.8	9.4
Total "Cushion"	0.0	1.6	4.5	12.2	12.7	13.1	44.0

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Uses of Funds (billions of dollars)

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Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
Less Offsets	0.0	-5.5	-17.3	-48.5	-56.2	-60.4	-187.9
States' Required Maintenance of Effort	0.0	-2.5	-7.4	-20.7	-21.7	-22.6	-74.9
Discontinued Medicaid Coverage	0.0	-2.0	-6.9	-19.8	-26.5	-29.8	-85.0
Basic Benefits	0.0	-1.9	-6.5	-18.5	-24.7	-27.9	-79.5
Net Wrap-around Benefits	0.0	-0.1	-0.4	-1.3	-1.8	-1.9	-5.5
Medicare Offset for Employed Beneficiaries	0.0	-1.0	-3.0	-8.0	-8.0	-8.0	-28.0
Total Spending	4.1	25.5	48.1	82.0	84.3	88.4	332.4
Deficit Reduction	11.0	2.1	-3.4	-8.1	20.2	35.8	57.7
TOTAL	15.1	27.6	44.7	73.9	104.5	124.3	390.1

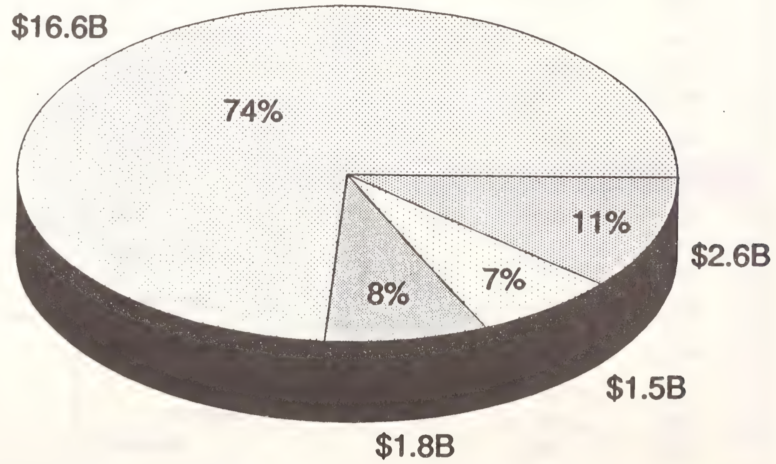
Distribution of Gross Discounts, 1995-2000 ($ billion)

Type	Amount	Percent
Gross Discounts		
Employer	$100	29%
▪ Private	98	28
▪ State/Local	2	1
Household	$184	53%
▪ Non-retiree	159	46
▪ Non-worker discounts to retirees	25	7
Retiree discounts	12	3%
Out-of-pocket	$9	3%
Discount "cushion"	$44	13%*
Total	$349	100%
Offsets		
Medicare	$28	15%
Medicaid	$160	85%
▪ Federal	85	45
▪ State/Local	75	40
Total	$188	100%
Net Discounts		
Total	$161	100%

* The cushion is 15% of the premium discounts, or 13% of total discounts

Chart 4

Employer Discounts by Firm Size



Total Discounts = $22.4 Billion

Firm Size:

< 25 | 25-49 | 50-99 | 100+

NOTE: Includes all employers subject to 7.9% payroll cap

Mr. McMillan. Over that 24-month period between the two forecasts the cost of these two programs increased, on a 5-year projected basis, by $151 billion, which is part of our problem. Medicare itself increased $51 billion.

I suppose my question generally is would you expect that CBO's progressions for the current year would be increased dramatically when they revise their estimates in January of 1994 as opposed to what they did in January of 1993?

Mr. Vladeck. I believe that on the Medicaid numbers, the CBO outyear estimates ought to be lower in their 1994 estimates than they are in their 1993—our Medicaid outlay numbers in fiscal 1993 have been running way below projections throughout the year, and CBO has taken that into account in its midyear adjustment.

Mr. McMillan. You are saying, I think, the forecast, or the budget, was some 16 percent over the prior year.

Mr. Vladeck. That is right. The actual Medicaid expenditures in fiscal 1993, will be significantly below that.

Mr. McMillan. I don't want to try to hold you to that, that is not quite fair at this stage of the game.

Mr. Vladeck. Fiscal year 1993 is over, so we should have a good sense, but I can't speak to the forecast.

Mr. McMillan. What about Medicare?

Mr. Vladeck. I honestly do not know what they will do. I am somewhat at a loss in commenting on CBO and how they do what they do in producing the kinds of numbers——

Mr. McMillan. Well, they are required to do it, and if you saw it was inaccurate, wouldn't you feel compelled to publicly say so?

Mr. Vladeck. If I understood the basis of their projections and believed they were wrong, I certainly would say so.

Mr. McMillan. Do you make your own projections?

Mr. Vladeck. Yes, we do.

Mr. McMillan. Would you make a promise to this committee that if CBO is off, you will challenge their projections?

Mr. Vladeck. And I understand the basis of it, I will make that promise to you.

Mr. McMillan. I will call you up and ask you, because I am a member of the Budget Committee and this has tricked us too many times, and I think, though, it gets to the issue that I really want to get to. Admittedly, it is hard to forecast open-ended entitlement programs, particularly in a dramatically changing medical provider landscape. And one of the challenges in health care reform gets to whether we are dealing with things influencing the private sector or the public sector, and are we going to be able to get some precision in the process.

If not, we are kidding ourselves. I don't think the public is going to stand for it. So I think it is important we have accuracy. Even though we may argue and disagree about this or that, how much confidence do you really have in the forecasts that are contained in the information that you gave us today?

Mr. Vladeck. In the savings projections, sir?

Mr. McMillan. Yes.

Mr. Vladeck. Well, let me——

Mr. McMillan. Let me add one other part of that question. Not only the savings projection, because we are not just projected sav-

ings, we are projecting costs. If costs increase in excess of our projected adjustments to a baseline, then we have not gotten anywhere and I think that is part of the problem. There are things going on out there that our legislative language and our rule-making does not control. It runs out of control.

Mr. VLADECK. Let me say relative to your question, that I have a reasonably high degree of confidence in the accuracy of those estimates in real dollars. But one of the problems with all these numbers and with our numbers has been that we have been so poor at estimating macroeconomic rates of inflation in particular and the relationship between real and nominal dollars, which are perhaps a third of the growth in health care outlays from time to time.

Now, in a sense, it should not make that much difference in the sense our revenues should grow in real terms, our revenues and our expenditures should grow at the same level regardless of the inflation rate. But to some extent we get misled and very confused looking at health care costs, because they are very sensitive to what is happening in the underlying economy, in terms of the underlying inflation rate. And to the extent we misestimate what CBO, what CPI is going to do or what PPI is going to do, we proportionally misestimate what health care costs are going to do, and it makes us look as though we are worse estimators than we are in some ways.

Mr. MCMILLAN. We do not do badly at estimating the overall rate of inflation, and I think the President's objective in this is to try to limit the rate of increase in health care costs to the base rate of inflation plus demographic changes that expand the programs, but what is happening is we have procedures out there that are getting implied and paid for that we did not predict would occur. The language of our laws is so open-ended that they get included in the reimbursement system, and so I am not saying we should not do those things, but we should call it before we do it.

Mr. VLADECK. I understand.

Mr. MCMILLAN. And predict it. That is all.

Mr. VLADECK. I understand.

Mr. MCMILLAN. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. Vladeck, under Medicare, under the proposal that is going to be offered to the Congress, the government would have the right to deny coverage for a prescription drug that the government deems too expensive. What exactly is the test for defining this measure? Is this very, very expensive or very, very, very expensive, or what is the test?

Mr. VLADECK. The test, very directly, Congressman, is the inability of the department and the manufacturer to negotiate an agreed upon price which Medicare will pay for the drug.

Mr. WYDEN. I guess my concern is, and I think all of us would recognize that this is a balancing act, because you need leverage. At the same time, you know, different people react to pharmaceuticals differently and if you went with maybe a prior approval kind of test rather than what you are talking about, maybe you could do the same thing in terms of having leverage and, at the

same time, you would have a system that would work for more individuals. Are you all looking at that as well?

Mr. VLADECK. We have looked at a number of things relative to pharmaceutical pricing, and I think the Secretary has expressed, I certainly can express to you, that in this very complicated area we are not convinced there is one best way to do this and are very much open to continuing discussions with you.

I, frankly, like the idea, just expressing a personal preference here, sir, of making as much of the issue of what Medicare will pay for a prescription drug, in effect, a negotiating process, as possible, rather than a formulistic formula; a numbers-driven process. But I think there are even some on both sides, and we are very much open to further consideration of that.

Mr. WYDEN. Another question I am interested in deals with the poorest seniors in the country. As you know, there is a program that protects the poorest elderly, the folks that cannot afford 25 percent of the premium. That is the qualified Medicare beneficiary program.

Under the bill, it looks like the program is continued and then in the next paragraph it looks like the program is taken away. What is the status of the qualified Medicare beneficiary program under the bill?

Mr. VLADECK. The program clearly continues, and all of our budgetary estimates assume the continuation of the programs.

We have been discussing with the States and among ourselves the extent to which it might be possible to federalize the administration of the QMB program, and then the question of how one would assure the State maintenance of efforts relative to that. And I think that is why that part of the drafting of the bill is potentially a little confusing. I am not sure that has entirely been worked out yet.

But the bucks for continuation are in the program. How the administration evolves under the reform is still being discussed.

Mr. WYDEN. I am interested in working with you all on it and I appreciate the answer, but the bottom line is you have told us the program is continuing and it is hard to follow.

One last question, on the drug issue again, is Medicaid has long had the same generic substitution rules you are all now proposing for Medicare. Medicaid pays for the brand version on multiple source drugs about 25 percent of the time. You have said there is a pretty decent chance Medicare is going to do the same thing. There have been a number of Medicaid programs that have gone to different approaches, which drives that percentage on the brand name down. Particularly Merrell Lab has a program that has gotten it down to about 5 percent simply by asking the pharmacists to submit a copy of the doctor's prescription when the brand name is medically necessary.

Are you all looking at the possibility of maybe doing that for Medicare as well, to see if again we can try to wring some more savings out by promoting generics?

Mr. VLADECK. I think I can honestly say we are now.

Mr. WYDEN. You are looking at it now.

Mr. VLADECK. Henceforth, we will be looking at it.

Mr. WYDEN. Good. We have to get some more savings out of these things that really end up not hurting people. I would hope that you would.

Mr. VLADECK. I thank you for that and as a result of your inquiry we will pursue that.

Mr. WYDEN. I am going to quit while I am ahead, Mr. Chairman. Thank you, Mr. Vladeck.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

There is a pretty general question, but the Clinton proposal really has no financing, per se. The cost containment is the financing, and we have been discussing it at some length now.

The estimates of cost savings can be good, but sometimes they are beyond our ability to predict. We do have some new entitlements here. They are predictably going to cost a lot, and if the cost estimates are off, we will have an explosion of the deficit.

That has caused some folks to say let us try to expand entitlements as we realize savings. It is not as much fun to do it that way but it is more prudent. Why has that way of thinking apparently been rejected?

Mr. VLADECK. I think there are two reasons why. Basically two reasons why. The first is we believe that some of these savings and over time the real core of these savings are only achievable or significantly more achievable in a world in which everyone is covered than in a world in which there are substantial parts of the population that are uncovered as a result of which you develop all these elaborate cross-subsidy schemes to subsidize uncompensated care in one form or another.

And, further, you still have incentives on the part of insurers and providers to dump uncovered or less well covered folks on to other providers who are out of the system altogether. Until you get over that hump and begin to have the universal entitlement, we think it is harder to do some of the things in terms of containing the rate of growth of cost and that efforts to control cost in a world of partial coverage tend to produce counterproductive or destructive behaviors that are very hard to prevent.

The second issue is on why we think we have to do this together is because I don't think it is entirely fair to say that the major mechanism of financing this plan is cost containment. It is an important mechanism, but if you add up the dollars, the major mechanism of financing this plan is the employer mandate. And even with the subsidies and the discounts for employers, the largest part of the new dollars coming into this system are dollars coming in from employers and their employees where there is not now an employer-employee contribution to health insurance. There also are close to $100 billion in new Federal tax revenues, as we discussed earlier.

So while it is certainly true that the savings from cost containment are an integral part of this, it is also true that the largest part of this is, the largest part of the financing for this system as a whole comes from employers and employees who are now outside the system, or the self-employed who are now outside the system. And this is a place where the benefit and the expenditure sort of

comes simultaneously and you cannot stagger one without the other.

At the same time, we do not want to be a position to tell folks not now paying for insurance that they are being forced to buy into a world that has no ceilings and no cost containment in it.

Mr. GREENWOOD. Has the administration made estimates of the total new contributions into the global health care budget that will come from employers and employees?

Mr. VLADECK. Yes, sir, they have. Dr. Thorpe, I know, has testified to those numbers—I don't have those tables with me—in other committees, not in this one. But we can try to provide you with that number.

Mr. GREENWOOD. In the event, and I have been here for most of these hearings, I may have missed some testimony. I would like that.

Mr. VLADECK. Be happy to do that.

Mr. GREENWOOD. And with that, Mr. Chairman, I would yield back the balance of my time.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Vladeck, we thank you very much. You have been very, very helpful to us. It has been a long morning. You have done an excellent job and I want to commend you for it. We look forward to working with you.

Mr. VLADECK. I look forward to my next appearance before the committee.

Mr. WAXMAN. Is that tomorrow? Get a good night's sleep. We are going to break now until 1:30. We will reconvene here at 1:30 to continue the hearing.

[Whereupon, at 12:50 p.m., the subcommittee recessed, to reconvene 1:30 p.m., this same day.]

AFTER RECESS

Mr. WAXMAN. The meeting of the subcommittee will come to order. Our next witness is Dr. Robert Shreve, a member of the board of directors of the American Association of Retired Persons. The AARP has been in the forefront of the debates over health reform.

Mr. Shreve, we welcome you to our hearing today.

Mr. SHREVE. Thank you, Mr. Chairman.

Mr. WAXMAN. Your prepared statement, without objection, will be made part of the record. We would like to ask you to limit the oral presentation to 5 minutes and there is a button on the base of the mike. Push it forward.

STATEMENT OF ROBERT SHREVE, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. SHREVE. Thank you, sir, and I appreciate you accommodating my travel arrangements. Mr. Chairman, members of the committee, my name is Bob Shreve. I am a member of AARP, the board of directors and on behalf of AARP, I would like to commend you, Mr. Chairman, and to—as well as the members of the committee on both sides of the aisle, for your attention to health care reform.

Rather than summarizing our statement, I would like to focus on a few key points. Health care reform is both a complex national issue and a very highly personal issue. That is certainly true in dealing with the Medicare program.

Here inside the Beltway, Medicare is a $150 billion system with hundreds of pages of laws and regulations, but to the millions of Medicare beneficiaries and to me, it is my health care program, and despite its shortcomings, such as gaps in benefits and some confusing paperwork, it is an enormously successful and popular program across all age groups.

If for some inside the Beltway Medicare is a balance dragging down the budget, to people beyond the Beltway it is a life saver without which they would sink. I say all of this to emphasize a critical point. Our health care system needs comprehensive reform and Medicare must be a part of that reform, but let's not confuse bold action with precipitous action, or throw out what works simply for change's sake.

A second point related to the first is the magnitude of the Medicare savings in the administration's proposal. Controlling health care costs throughout the system must be a central goal of health care reform and Medicare can be expected to be a part of that reform.

But the magnitude of the proposed savings, $124 billion, is alarming on its face. Over the past decade, Medicare has absorbed roughly $200 billion in cuts, $56 billion just in the recent OBRA. Medicare now pays an average of 65 cents on the dollar compared with private payers.

Increasingly we are hearing from our members that they are paying for these Medicare cuts in reduced access. Absent systemwide cost containment, the association will oppose further efforts to cut Medicare.

AARP supports strongly retaining Medicare as a distinct program rather than dismantling it or forcing beneficiaries into State-based alliances. If Congress decides to grant a limited number of States the authority to integrate Medicare into broader State-wide systems, the association urges that States be required to demonstrate, not simply assure, that first Medicare beneficiaries will receive the same benefits as the under 65 population, and second, that Medicare funds are earmarked so that States cannot divert such funds for other purposes.

We are not convinced that States could handle a take-over of the Medicare program. It will take time for the States and alliances to learn how to run a new system without adding 36 million more people than are already in the system.

Medicare eligible individuals who do get health coverage in alliances are likelier to be healthier than the remaining pool of Medicare beneficiaries because they are younger and/or working.

We are concerned that this could lead to a withering of the actuarial base of Medicare unless the risk adjustment system takes great care to avoid this outcome. AARP is also concerned that the President's plan would not provide the same coverage, for example, annual limit on total out-of-pocket expenses and low income protections for Medicare beneficiaries as it would for the younger populations.

We hope that these and other gaps can be filled as the proposal works its way through Congress. The need for health care, as well as the need for assistance to pay for that care, does not decline when one celebrates a 65th birthday. Indeed it only increases for most.

Another way to think about Medicare is as its own national health alliance. Under the President's proposal, each health alliance would community rate premiums, allow choice between fee for service and managed care plans, and limit health care premiums and payments to providers. Medicare has already demonstrated success in these areas.

In conclusion, Mr. Chairman, the President's plan incorporates many of the features that AARP has supported in its own proposal. I assure you that we will work with the Congress in a bipartisan way to ensure that comprehensive benefits are guaranteed to Americans of all ages in a final health care plan.

Thank you.

Mr. WAXMAN. Thank you very much for your testimony.

[Testimony resumes on p. 426.]

[The prepared statement of Mr. Shreve, follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

ROBERT SHREVE

Member, Board of Directors

Good morning. My name is Robert Shreve. I am a Member of the Board of Directors of the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today on the future of the Medicare program under health care reform.

America needs comprehensive health care reform. Americans need bold, not timid, steps now.

Comprehensive health care reform means:

- A guarantee that all individuals have access to and coverage for health and long-term care;

- System-wide cost containment that slows the explosive growth in health spending;

- Comprehensive benefits, from prenatal care and prevention to prescription drugs and long-term care;

- Broad-based, fair and affordable financing, so that government, businesses, and individuals all pay their share and everyone is protected against the high costs of care; and

- Consumer-centered governance of the health care system.

While AARP has not yet endorsed any specific health care reform plan, we believe the President's proposal provides the strongest and most realistic blueprint to date for achieving our goals. At the same time, we commend the members of Congress in both parties who have introduced proposals that would achieve universal coverage.

We commend the President for including the following critical provisions in the Health Security Act:

- a home and community-based long-term care benefit for disabled persons of all ages;
- coverage of prescription drugs on similar terms for Medicare beneficiaries as for all other Americans; and,
- protection for pre-65 retirees.

AARP's "Health Care America"

AARP's proposal for comprehensive health care reform, "Health Care America," was developed with the extensive involvement of AARP members across the country. Its centerpiece is universal coverage through a strengthened and expanded Medicare program in which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care benefits. Employers would be required to contribute to the cost of their workers' benefits, either through the expanded Medicare program or through private coverage. In addition to ensuring access, the system would foster choice, diversity, and innovation in the delivery of health services. Finally, the system would be accountable to consumers through a new Federal Health Care Commission that would set spending targets and establish other rules.

"Health Care America" reflects the Association's commitment to improving the quality of life for all generations -- a commitment we believe is shared by President and Mrs. Clinton, members of Congress, and the American people.

Strengthening Medicare

AARP strongly supports the President's proposal to retain and strengthen Medicare rather than dissolve it or force beneficiaries into state-based alliances. We believe that ultimately the entire health care system should be seamless. We also believe that strengthening Medicare at this time will help move toward a more integrated health care system in the future.

What's Good About Medicare

Medicare is the cornerstone of health care coverage for older Americans. Since its inception, Medicare has dramatically increased access to health care for those age 65 and over and the disabled by guaranteeing that coverage is available regardless of health status and by attempting to keep costs for Medicare-covered services affordable. Today, about 36 million Medicare beneficiaries receive important benefits like physician services, hospital care, and home health care.

Beneficiaries can choose where and from whom to receive care -- from physicians or certain non-physician providers, through a standard fee-for-service setting or through managed care organizations.

Medicare also seeks to guarantee the quality of care through an external system of peer review and quality standards. Peer Review Organizations (PROs) independently monitor care, investigate beneficiary complaints, and review hospital discharge decisions.

While rising health care costs are a problem throughout the health care system, Medicare has established important mechanisms that have consistently reduced the program's anticipated growth rate. In the 1980's Congress established the prospective payment system (PPS) to help control growth in Medicare hospital costs and the RVS fee schedule and volume controls to address the explosion in physician costs. Although Medicare physician payment reform is still in its early phases of implementation, both strategies have proven effective in slowing Medicare's costs. The Congressional Budget Office recently found that while real Medicare spending grew at an annual per-capita rate of 3.1 percent between 1985 and 1991, real national health spending grew at an annual per-capita rate of 4.8 percent.

Medicare's low administrative costs -- about 2 percent of program outlays in 1992 -- help maintain its reputation as one of the more efficient federal programs. By contrast, administrative costs of private health insurance range from 5.5 percent to 40 percent of benefit costs.

Medicare has consistently maintained strong public support across all age groups.

Major Gaps in the Medicare Program

While Medicare guarantees that virtually no one 65 or older is uninsured, there remain substantial gaps in coverage, inadequate protections against high out-of-pocket costs, and access problems. The President's plan would address some of these gaps.

No prescription drug coverage. The combined effects of high pharmaceutical prices and the lack of Medicare coverage for prescription drugs have significantly limited access to needed drug therapies for older Americans. A recent national survey sponsored by AARP showed that:

- older Americans use significantly more prescription drugs than other age groups to maintain their health;
- prescription drug insurance coverage declines rapidly as age increases; and
- out-of-pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

As a result, many older Americans cannot afford the prescription drugs they need and are denied access to essential, often life-saving, medications -- compromising their health status and making them more likely to receive unnecessary and more expensive acute care. Many more compromise their prescription instructions, thereby reducing their efficacy and increasing the likelihood of higher acute care costs.

AARP commends the President for including a Medicare prescription drug benefit in his plan.

No long-term care coverage. Although Medicare provides limited coverage for medically necessary rehabilitative services by skilled nursing facilities and home health agencies, the program fails to cover long-term chronic care needs. Consequently, the majority of long-term care services are paid for out-of-pocket. Nursing homes cost an average of $30,000 per year -- and can easily exceed $60,000 -- and home health care can cost from $50 to $150 per visit. The average annual out-of-pocket payment for long-term care among all elderly

Americans is over $900. Nursing home costs alone account for over 80 percent of all annual out-of-pocket expenses of the elderly in excess of $2,000. According to a survey conducted in the fall of 1991 by DYG, Inc., three-fourths of Americans (18 and older) were "very concerned" about paying for the cost of long-term care.

The President's health care reform proposal is a serious start toward addressing the unmet long-term care needs of millions of American families. The proposal is a dramatic improvement over our current "non-system."

Minimal preventive benefits. Medicare does not cover most preventive services such as routine physical exams, colorectal and prostate cancer screenings, and many immunizations. Regrettably, the President's plan would not change this short-sighted Medicare policy.

Balance billing. Beneficiaries now face significant out-of-pocket costs due to physician charges up to 15 percent over the amount approved by Medicare. And for some services -- such as flu shots -- balance billing limits don't even apply. In 1992, Medicare beneficiaries paid $1.3 billion in balance billing charges -- over and above required cost sharing. AARP commends the President for proposing to eliminate this practice both in the Medicare program and in alliance plans as well.

High outpatient coinsurance. While Medicare's reimbursement for outpatient surgical and radiological services is based on the Medicare-approved amount, a beneficiary's required coinsurance is based on actual hospital charges. As a result, beneficiaries end up paying anywhere from 37 to 54 percent in coinsurance instead of the standard 20 percent for most Part B services. The President's plan does not address this inequity, and could make it worse.

No out-of-pocket limits. Unlike many employer-sponsored health plans today, Medicare does not limit the amount individuals must pay out of pocket for covered services. As a result, beneficiaries who are sicker and require substantial hospital and physician care often pay thousands of dollars each year in cost sharing. Or, they can buy expensive medigap plans to help protect against these high costs. Out-of-pocket health care costs for older Americans -- even when premium payments and long-term care costs are excluded -- are substantially more than for younger populations (see Chart 1).

Unfortunately, the President's plan does not establish an annual out-of-pocket limit on cost sharing for Medicare beneficiaries (unless they join an HMO) even though it does for all other Americans.

Inadequate low-income protections. Medicare also does not provide adequate protections for low-income beneficiaries. About 10 percent of Medicare beneficiaries are too poor to afford medigap coverage but are not poor enough to qualify for Medicaid or the Qualified Medicare Beneficiary (QMB) program. The QMB program pays Medicare premiums and all Medicare cost sharing for persons below the poverty level but pays only for Part B premiums for those between 100 and 120 percent of the poverty level.

The President's plan would provide federal subsidies for premiums and coinsurance for individuals up to 150 percent of poverty -- but only for those under the age of 65. AARP strongly recommends that health care reform legislation offer equal protections for low-income Medicare beneficiaries.

Low provider payment rates and access problems. There is a widening chasm between what Medicare reimburses and what the private sector pays for virtually all inpatient and outpatient care (see Chart 2). Assuming that private insurance rates reflect 100 percent of submitted charges, Medicare pays on average only 65% of the private rate. This gap in payments has resulted in greater cost shifting onto the private sector and, in some areas of the country, less willingness on the part of physicians to treat Medicare patients.

The Future of Medicare Under Health Care Reform

Older Americans want comprehensive reform of the health care system for all Americans because they see their costs -- as well as those of their children and grandchildren -- rising rapidly and experience real gaps in coverage. What they don't want and can't afford are "solutions" that would erode the Medicare protections that they have now.

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<u>Medicare Savings and Financing of Reform</u>

The President's plan would reduce the growth in Medicare spending by $123 billion between 1996 and the year 2000. These savings come on top of the $56 billion in Medicare savings enacted just three months ago in the 1993 budget reconciliation act, the $43 billion in Medicare savings enacted in 1990, and more than $80 billion in cumulative Medicare savings throughout the 1980s. Additional limitations on Medicare reimbursement levels will do little to either slow the overall rate of health care cost growth in the economy or provide a long-term solution to the budget deficit unless private sector health care spending is also limited. <u>In the absence of system-wide cost containment, AARP would strongly oppose further Medicare cuts -- especially large-scale cuts such as $123 billion</u>.

AARP generally supports the President's proposal to limit the growth in private insurance premiums. If done right, premium limits could protect individuals and families from high costs in a way that is easily understood and broadly effective. Premium limits in the private sector -- with effective backup mechanisms to provide real enforceability -- would finally begin to address cost growth where heretofore there has been no constraint on spending.

Even with comprehensive reform, we are doubtful that the Medicare program could sustain such enormous reductions without creating quality and access problems for beneficiaries. It appears that in the President's plan the growth in Medicare spending would be reduced at a much faster pace than in the private sector.

The Association will continue its assessment of Medicare cuts -- which are of a magnitude that is alarming on its face -- as we examine the feasibility and effectiveness of proposed savings in the private sector.

One Medicare savings proposal stands out as a significant departure from the current program -- the proposal to income-relate the Part B premium. AARP has strongly opposed this proposal outside the context of health care reform, arguing that it would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending. We also believe that if Part B premiums are income-related, then private-sector premiums should be income-related as well. In 1993 alone, the federal government will lose $48

billion by providing tax breaks for employer and employee health care premiums. This provision is one of the fastest growing "tax expenditures" in the budget.

It does not seem fair that taxpayers would continue to subsidize the health care premiums of a Wall Street executive with a salary of more than one million dollars a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced. If Congress and the President believe that "income relating" premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country -- including the Congress itself.

The proposed Medicare savings, even if they can be achieved, are not a broad or permanent financing source for health care reform. Once the system is made more efficient, we will need to identify more lasting funding sources for the public cost of health care delivery.

Medicare and Health Alliances

AARP strongly supports the President's intention to retain Medicare as a distinct program rather than dismantle it or force beneficiaries into state-based alliances. There are four fundamental reasons for preserving Medicare as a separate program under the President's plan.

First, health alliances -- as currently proposed -- do not provide equal coverage for Medicare beneficiaries. Those who have suggested forcing Medicare beneficiaries into alliances at the outset ignore the fact that older Americans would get worse coverage and pay more in premiums than others in the alliance. Until the alliance system can provide equal coverage for older Americans at similar rates, they should not be "incented" into the alliance system. The first step toward integration of Medicare should be to expand Medicare benefits and out-of-pocket protections. At a minimum, the over-65 alliance enrollee should enjoy the same benefit package, cost sharing, etc. that the under-65 enrollee has.

The President's plan would not provide the same coverage (i.e., the same benefit package, the same individual cost-sharing requirements, the same annual

limit on total out-of-pocket spending, and the same low-income protections) for Medicare beneficiaries as it would for younger populations (see Chart 3). We hope that these gaps can be filled as the proposal works its way through Congress. The need for health care, as well as the need for assistance to pay for that care, does not decline when one celebrates his or her 65th birthday. Indeed, it only increases for most.

Second, Medicare can be thought of and would operate more efficiently as its own national health alliance. Under the President's proposal, each health alliance would constitute a separate "risk pool" within which premiums would be community-rated. Medicare has operated in this manner for the past twenty-eight years. Alliances would allow individuals and their families to choose between fee-for-service and managed care plans. Medicare already allows beneficiaries to choose HMOs or PPOs in areas where they are available (relatively few Medicare beneficiaries are in HMOs due to the lack of incentives for HMOs to market to older persons and the limitations of the AAPCC). The President's plan would expand managed care choices so that the incentives that apply to Medicare beneficiaries are the same as those within regional alliances. Lastly, alliances would be charged with limiting health care premiums and payments to providers -- an area in which Medicare has already demonstrated some success.

Third, older Americans are very reluctant to "give up" Medicare with which they are very familiar for a new and untested approach. Seniors rely greatly on Medicare for their health care needs, despite the gaps in Medicare coverage. The system functions well for 36 million beneficiaries.

Fourth, we are not convinced that states would be able to develop and maintain consistent, high standards with respect to the oversight and enforcement that would be necessary to support a takeover of the Medicare program. It will take time and experience for the states and alliances to learn how to run a new system without adding 36 million more people into it.

Medicare Changes Under the President's Plan

While retaining Medicare as a separate program, the President's plan would make some significant changes. Based on our review of the draft legislation presented by the President two weeks ago, we have a number of suggestions, questions, and concerns about these changes.

Treatment of Working Medicare Beneficiaries

It is our understanding that Medicare beneficiaries who remain in the workforce would be treated as employees and their coverage would be provided through the health alliance, not through Medicare. These older workers and their spouses would be offered the same package of benefits as workers under the age of 65.

Before it will be possible to assess the impact of this policy on older workers, a number of issues need clarification:

- A lack of clarity about how premiums for older workers will be calculated. What is the older worker's liability for the employee share of the premium? What is the premium liability for older part-time workers whose employers pay a pro-rata share of the premium? Will these individuals end up shouldering a greater proportion of their health care costs than they would have under Medicare?

- Uncertainty about what happens to beneficiaries now in the workforce and those who will retire. What happens to beneficiaries who are now working? Will they lose their Medicare coverage? Do they end up with lesser coverage than they had before turning 65? What happens to older workers when they do retire? Are they provided with the option of remaining in the alliance plan or are they automatically covered under the Medicare program? How are older workers who are periodically employed and unemployed covered, and how is their transition from one program to another accommodated?

- o Whether there is an impact on the Medicare secondary payor program. Currently, older workers who have chosen their employer plan as primary coverage still have Medicare secondary payor protection in the event that the employer plan pays only a portion of the charge for a service or the employee has exhausted his/her primary coverage. Do any of the Medicare secondary payor provisions continue to apply to older workers? Will older workers forfeit Medicare secondary payor protection?

Alliance Option At Age 65

All individuals enrolled in managed care plans through an alliance at age 65 would be permitted to elect to either remain in the alliance or enter the Medicare program. It is our understanding that with the exception of working Medicare beneficiaries, the choice to remain in the alliance would be limited to individuals enrolled in managed care organizations. Once again, a number of issues and questions arise:

- o Those who remain in alliances are likely to be healthier -- at a minimum, because they are younger -- than the remaining Medicare population. We are concerned that this could lead to a withering of the actuarial base of Medicare unless a risk-adjusted payment mechanism is incorporated.

- o What premium would a 65-year old remaining in an alliance pay?

State Waivers Allowing Takeover of Medicare Program

The President's plan would allow states to integrate Medicare into their regional alliance or single-payer systems.

In applying to HHS to integrate Medicare, states could choose which classes of Medicare beneficiaries to cover -- elderly, persons with disabilities, and/or individuals with end stage renal disease. The state would have to make certain assurances concerning coverage of full Medicare benefits, quality assurance,

and use of Medicare funds only for Medicare purposes. These provisions raise a number of concerns.

We are concerned about the fragmentation of Medicare, the only health program that is national in scope and coverage. Allowing states to pick and choose which Medicare beneficiaries to bring into their systems would allow differential treatment of Medicare beneficiaries.

We also question whether simply requiring states to make "assurances" is sufficient for the federal government to permit such a massive change in Medicare.

At this point, we do not believe that there is sufficient evidence to support state control over the Medicare program. If Congress decides to grant a limited number of states the authority to integrate Medicare into broader systems, the Association urges that such authority be conditioned on clear requirements and procedures that include ongoing federal oversight. Interested states must demonstrate, not simply "assure," and the federal government must be able to validate that:

- Medicare beneficiaries will receive the same benefits as the under-65 population as well as appropriate access and high quality of care; and

- Medicare funds are earmarked for use by beneficiaries, and that states cannot divert such funds for other purposes. We believe that these requirements are necessary given the recent experience with state use of questionable Medicaid financing techniques. We are concerned that states not be allowed to take advantage of Medicare funds in the same way.

We also have concerns about a "closed" process for application and approval. The proposal for Medicare integration in the Health Security Act is similar to current Medicaid waiver authority which entails application from the state executive branch and approval from the Secretary of HHS. We strongly recommend that applications be developed and reviewed in as open an arena as possible at both the state and federal levels. States should be required to enact

legislation authorizing waiver application, and review of the application at the federal level should include a public comment period.

Medicare Managed Care Options

The President's proposal recognizes that the current managed care options available to Medicare beneficiaries are limited. In an effort to stimulate greater involvement on the part of both beneficiaries and participating health plans, the proposed legislation contains several provisions intended to expand the availability of these options. These include: (1) establishing uniform open enrollment periods for all managed care plans as well as Medigap policies; (2) establishing uniform termination of enrollment; (3) requiring the Secretary of HHS to develop and distribute uniform comparative informational materials for all participating plans; (4) authorizing the Secretary to make additional outlier payments to plans for certain high risk enrollees; and (5) requiring all managed care plans to offer a point of service option.

It is a reasonable objective to expand the availability of managed care options in order to determine whether alternative delivery systems can gain widespread support among older Americans. At the present time, there is simply not sufficient enrollment in managed care plans to draw definitive conclusions about their appropriateness for or acceptability to Medicare beneficiaries. As of October 1993, there were approximately 1,763,000 Medicare beneficiaries enrolled under risk contract HMOs -- only 5 percent of total Medicare beneficiaries. An additional 450,000 beneficiaries participated in the Medicare Select program, HCFA's 15-state PPO demonstration. Thus, about 7 percent of all Medicare beneficiaries received services through managed care organizations. This compares to about 41.4 million enrolled in HMOs and an additional 122 million eligible to use PPOs -- well over 60 percent of the under-65 population.

AARP believes that Medicare beneficiaries should have managed care available as an option and we support approaches to level the playing field to enable managed care organizations to compete equally for Medicare beneficiaries. The President's proposal to encourage the expansion of managed care options for Medicare beneficiaries is generally consistent with this position. Conforming the open enrollment periods for all participating plans will enable beneficiaries

to consider all the options available to them and should facilitate informed consumer choices. Distributing comparative literature should, likewise, enhance beneficiary understanding of the choices available to them.

AARP has long supported improving the HMO reimbursement methodology under Medicare to encourage reasonable participation levels in the Medicare program on the part of health plans and to ensure that Medicare payments to such plans are set at appropriate levels and are cost effective. There appears to be some evidence that an outlier pool payment could provide health plans some protection against high unanticipated risks. To the extent that such a payment will increase plan participation in the Medicare program and will be a cost effective use of the Trust Funds, we believe that it would be worthwhile to test its efficacy.

Medicare Quality Assurance

The Association welcomes many of the President's initiatives to improve the quality of care, including consumer surveys, uniform encounter and claims forms, and quality and performance measures. However, it will take a long time to develop and implement the data systems which are envisioned, and many critical performance and quality measures -- particularly those which measure the quality of care for persons with chronic physical and mental illnesses -- are not yet available. Moreover, it is not clear in the President's proposal whether the quality system would apply to Medicare beneficiaries.

While consumer information is a critical component in the overall quality assurance strategy, it is only one piece. As proposed, the plan does not identify any entity or entities to be responsible for protecting consumers from poor quality care.

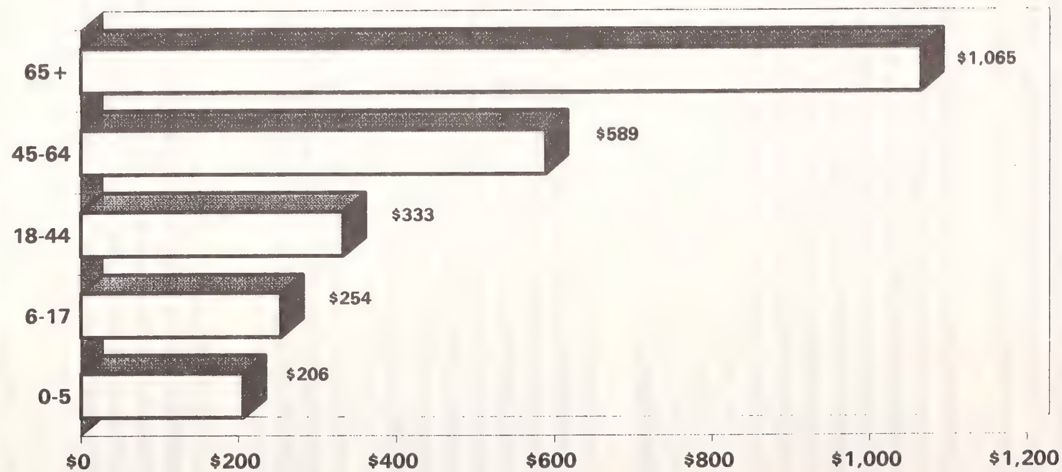
We are concerned that the President's proposal eliminates the PRO program and crucial patient appeal rights and procedures without providing for a successor organization. An independent, external oversight body will continue to be needed in Medicare to assure that quality of care does not suffer, especially during a time of unprecedented budget cuts and rapid delivery system restructuring.

In conclusion, Mr. Chairman, AARP commends the President, as well as the many members of Congress on both sides of the aisle who have brought the issue of health care reform to this stage. The President's plan incorporates many of the features that AARP has supported in its own proposal.

AARP will work with the Congress in a bipartisan way to ensure that comprehensive benefits are guaranteed to Americans of all ages in a final health care plan. Strengthening Medicare is a critical step toward that guarantee.

CHART 1

Average Out-Of-Pocket Health Expenditures Per User By Age, 1987

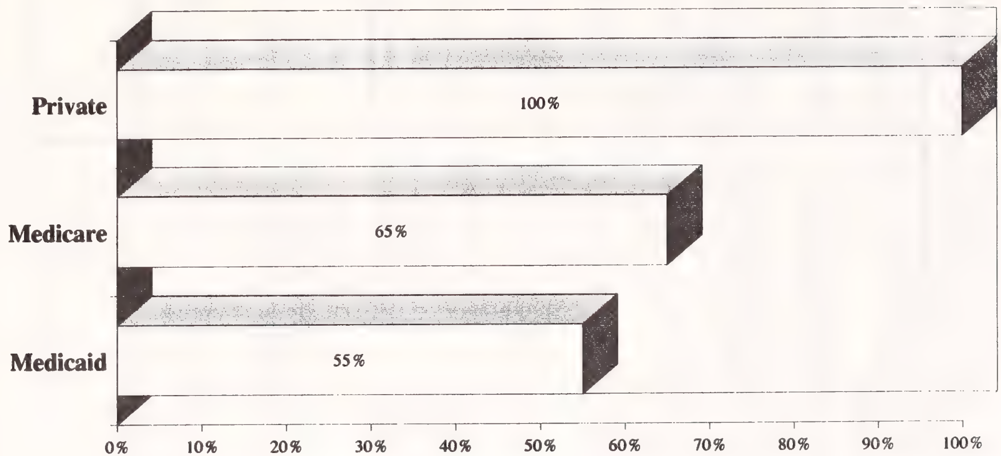


Note: Chart does not include premiums or long-term care costs.

Source: AHCPR, NMES

CHART 2

Gap in Payment Rates Between Medicare, Medicaid and Private Insurance



Note: Comparison assumes private insurance payment rates reflect 100% of submitted charges. In some cases, private insurance rates will be less than submitted charges.

CHART 3, pg. 1

HSA Standard Benefits versus Medicare Benefits (Revised)[1]

	HSA Medical Benefits		Revised Medicare (Fee-for-Service)[2]	
	Low Cost Sharing Plan: No Deductible High Cost Sharing Plan: Deductible: $200 ind./$400 family per year		Part B Deductible: $100/year Hospital Deductible: $676/benefit period (1993)	
	Stop-loss: Max. $1500 ind./$3000 family per year		Stop-loss: None	
	SCOPE OF COVERAGE	OUT-OF-POCKET	SCOPE OF COVERAGE	OUT-OF-POCKET
Inpatient Hospital Care	Including: • Semi-private room and board • Operating & recovery room costs • General nursing services • Lab tests • No limit on covered days	Low: no copayment High: 20% coinsurance	Including: • Semi-private room and board • Operating & recovery room • General nursing services • Lab tests • 90 days per benefit period	Deductible: $676 for each benefit period (1993) Coinsurance days: (1993) 61-90 = $169/day 91-150 = $338/reserve day 151+ = beneficiary pays 100%
Outpatient Hospital Care	• Outpatient hospital services	Low: $10 per visit High: 20% coinsurance	Surgery Radiology Diagnostic	20% of hospital charges (currently equals 50% coinsurance)
Physician Services	Visits in physician offices & institutional settings	Low: $10 per visit High: 20% coinsurance No balance billing	Visits in physician offices and institutional settings	Coinsurance: 20% Deductible: $100/year Balance billing eliminated
Outpatient Laboratory & Other Services	Lab tests, radiology, and diagnostic services	Low: no copayment High: 20% coinsurance	Lab tests	New 20% coinsurance on all lab tests performed in physician offices and other outpatient facilities
Outpatient Rx Drugs	As medically necessary.	Low: $5 per RX High: Separate $250 deductible; 20% coinsurance, applies to stop-loss	Newly covered under HSA	Separate $250 deductible; 20% copayment; stop-loss of $1,000
Home Health Care/ DME	Home health care only as inpatient alternative; reassessment after 60 days	Low: no copayment High: 20% coinsurance	As medically necessary.	New 10% coinsurance for home health visits except those within 30 days of hospital discharge; 20% coinsurance for durable medical equipment.
Post-acute Nursing Facility	100 days of skilled care in SNF or rehabilitation facility Only as hospital alternative	Low: no copayment High: 20% coinsurance	100 days of skilled nursing facility care per benefit period. 3-day prior hospitalization required.	No coinsurance for first 20 days; coinsurance charge of $85.00 per day applies from the 21st through 100th day for each benefit period.
Hospice	• As medically necessary for the terminally ill	Low: no copayment High: 20% coinsurance	• As medically necessary for the terminally ill	• No coinsurance; minimal payments for inpatient respite care & Rx drugs

[1] 10/13/93 draft based on our current understanding of the Health Security Act.

[2] Note: Medicare HMOs/CMPs are required to offer at least the Medicare services listed in this chart. Often, however, they may offer additional benefits, reduced cost-sharing, or both.

CHART 3, pg. 2

Mental Health[3]	• Inpatient psychiatric care: 30 days per episode/60 days per year	Low: no copayment High: Separate one day deductible per episode; 20% coinsurance (apply to stop-loss)	• Lifetime limit of 190 days in freestanding psych. hospitals; limit on days in gen. hospitals same as for physical disorders (see above)	• Deductible & coinsurance the same as for inpatient care for physical disorders (see above)
	• Intensive nonresidential care covered at discretion of plan; limit of 120 days per year; first 60 days, trade 2 days for 1 inpatient day	Low: no copayment High: 20% coinsurance	• Partial hospitalization; only as inpatient alternative	• 20% coinsurance
	• Outpatient therapy limited to 30 visits per year; at plan's discretion, trade 4 visits for 1 inpatient day beyond 30 visits	Low: $25 per visit; High: 50% coinsurance (does not apply to stop-loss)	• Outpatient therapy--no limit on covered visits	• 50% coinsurance
	• All other outpatient services, such as diagnostic evaluation and medical management.	Low: $10 per visit High: 20% coinsurance (does not apply to stop-loss)	• All other outpatient services, including diagnostic evaluation and medical management	• 20% coinsurance
Dental[3]	• Children < 18 only; prevention and treatment • Emergency dental treatment for adults	Low: $10 per visit High: Separate $50 deductible for treatment services; 20% coinsurance	• Outpatient dental generally not covered	• Patient pays full cost
Vision Care	• Vision prevention and treatment; eyeglasses for children only	Low: $10 per visit High: 20% coinsurance	• Routine exams, hearing aids & eyeglasses not covered.	• Patient pays full cost
Preventive Services	• Routine check-ups; mammograpy, Pap, & other screenings; immunizations; prenatal & well-baby care. • Schedules for visits/ screenings apply	Low: no copayment High: no coinsurance or deductible	• Mammography (schedules apply) • Select immunizations • Pap (schedules apply)	• 20% coinsurance • 20% coinsurance, but no cost-sharing for pneumococcal • No coinsurance or deductible.
Low-Income Protection	(l) Those below 150% of poverty not required to pay more in cost sharing than specified in the low cost sharing option. (2) AFDC & SSI families: copayments reduced to 20% of low cost-sharing amounts, e.g., $2 rather than $10 per visit. (3) Subsidizes premiums for those with incomes below 150% poverty. (4) Caps premium contributions for those with family incomes under $40,000/year at 3.9% of their incomes.		**QMB/SLMB Program** o Covers premiums/cost sharing for individuals at or below poverty o Covers premiums only for 100%-110% of poverty by 1993; and by 1995, for 110%-120% of poverty.	

[3] Beginning in the year 2001, HSA benefits package expands: (1) dental care to adults and (2) mental health care by removing day/visit limits on inpatient and outpatient care and lowering cost-sharing amounts to the same as for physical illness.

Mr. WAXMAN. You testified that the health alliances described in the President's plan would not treat Medicare beneficiaries fairly. You stated that older Americans would get worse coverage and pay more in premiums than others in the alliance.

This seems to me to be in sharp contrast to the comments we heard earlier from Mr. Vladeck. He suggested that the President's plan would give working Medicare beneficiaries more choice and offer them the same premium as others in the alliance, and as you point out, the President's plan includes benefits for alliance plans that are not currently available in Medicare.

Could you comment further on why you believe that alliance plans would not be an acceptable option for Medicare beneficiaries?

Mr. SHREVE. Well, we think first of all that Medicare beneficiaries are comfortable, they feel secure in the plans that they are in. I don't think all of the details have been revealed to us in what is likely to be involved in all of the alliance plans.

There seems to be—it doesn't seem to be a seamless program in terms of benefits, at least in what we have seen in print up to this point, and so for that reason, we have had those concerns that we have expressed.

Mr. WAXMAN. I asked Mr. Vladeck earlier whether the proposed Medicare cuts in the President's plan were appropriately coordinated with the transition to universal coverage.

In your testimony, you argue that even with comprehensive reform, you are doubtful that the Medicare program could sustain such enormous reductions without creating quality and access problems for beneficiaries.

As I said to Mr. Vladeck, there doesn't appear to be any systematic evidence of access problems, but I don't think we can afford to wait for conclusive proof in that regard.

I would like to ask you if the AARP has conducted any surveys of Medicare beneficiaries that provide information about whether they are having a harder time finding providers that will accept Medicare?

Mr. SHREVE. We indeed have—do periodically conduct surveys of membership, and it seems that—and I can get more specific details to you in writing later, Mr. Chairman, but it seems that each time there are cuts to the Medicare program, we do have a flurry of reports that access has been reduced.

Mr. WAXMAN. I was interested in your comments about quality assurance, both for Medicare and private plans. You seem a little skeptical about the likelihood of putting in place the quality measures called for in the President's plan.

You note, and I certainly agree, that the authority for enforcement of quality standards is not fully specified, and you oppose repeal of the Medicare peer review organizations without identifying a successor to perform external quality review of the system.

Do you think we should expand the PRO program to carry out quality assessment of private plans, and what kind of organization should be responsible for quality monitoring?

Mr. SHREVE. Well, as you know, we have certainly supported the PRO model and found that it has been useful, that it has done what it was intended to do, we believe. We have certainly been a part of that.

Lacking some specifics about what is likely to be put in place, we are skeptical of that transition period, particularly where there may not be anything in place that would serve the same kind of role that the PRO successfully fulfills now.

Mr. WAXMAN. You probably know that there is a great deal of talk about considering an amendment by Representatives Penny and Kasich in the House either this weekend or early next week.

Could you tell us what position AARP has taken on this amendment?

Mr. SHREVE. Well, frankly, Mr. Chairman, we are very concerned about the implications of the amendment. First of all, more than a third of all of the cuts that are the budget deficit reduction cuts that are involved in the Penny-Kasich plan come from Medicare, and, again, as we have indicated, every time there is a Medicare cut, we face more threats of a reduction in access, that more than one-third at 35 or 36 percent of cuts that would come through the Penny-Kasich bill would come right out of the pocketbooks of Medicare recipients.

The addition, for example, of the copayments on the home health care provisions would, on the average, amount to about $70 a month. For those people, for the elderly over age 85, which is basically a female population, those cuts could exceed $90 per month, and that is on top of the already $200 a month that is projected as an average out-of-pocket expense for Medicare recipients in 1994. So it gives us great concern.

Mr. WAXMAN. Are you saying that even if some of these cuts might be reluctantly accepted in a comprehensive health care reform, you think it would be viewed very differently as a deficit reduction action?

Mr. SHREVE. I am sorry?

Mr. WAXMAN. Well, if we have some of these Medicare cuts being proposed by the President for the purposes of a comprehensive health reform, this Penny-Kasich amendment may well take some of those very same cuts and apply them for deficit reduction. Does that concern you?

Mr. SHREVE. Well, we have, as an association, been concerned about the deficit for a long time, and we have really stepped up to the plate I think on more than one occasion to accept what we considered was our share of pain in order to help deficit reduction, because I want to assure you that those of us that are members of the association realize that the deficit is not something that is a problem for us alone, but we realize that that deficit affects our children and our grandchildren, and so we are very much aware of that.

We are also very committed to the notion of health care reform and ultimately perhaps a seamless system of health care reform.

The reductions that might come from Medicare or other programs that would be designed to make systemic changes in the health care program and health care reform would certainly be something that we could support.

Mr. WAXMAN. What is the view of the AARP of a proposal that would means test the premium, or income test the premium rather, and remove the subsidy from the government for premiums for people with incomes above a certain amount——

Mr. SHREVE. The——

Mr. WAXMAN [continuing]. With no improvement in Medicare benefits for those people.

Mr. SHREVE. The association's view of means testing the program for people of the higher incomes is not something that we think should be singled out for Medicare beneficiaries.

One of the fastest growing deficit sections of the budget is really the very large subsidy that is given to people in—of means as tax breaks on health insurance premiums, both for employers as well as individuals, and in order to keep equity in the system, we would be very opposed to means testing Medicare recipients, four out of five of whom are living in households where the annual income is less than $25,000.

We would be very concerned about that unless there was not a comparable thing. In other words, if means testing is OK, we would like to see everybody be involved in means testing.

Mr. WAXMAN. Thank you very much. I want to commend you on your testimony and recognize Mr. Greenwood for questions he might wish to pursue.

Mr. SHREVE. Thank you.

Mr. GREENWOOD. Thank you, Mr. Chairman. I apologize for not being here, sir, for your testimony. I was a little confused about the schedule.

I also am a bit confused by some portions of AARP's written testimony on the proposed Medicare cuts, and I would like to see if you can clarify AARP's position. Page 7 of AARP's testimony states, quote, "In the absence of system-wide cost containment, AARP would strongly oppose further Medicare cuts, especially large-scale cuts such as $123 billion," close quote.

It then goes on to say that, quote, "Even with comprehensive reform, we are doubtful that the Medicare program could sustain such enormous reductions without creating quality and access problems for beneficiaries," close quote.

Then on page 8, the testimony states, quote, "The proposed Medicare savings, even if they can be achieved, are not a broad or permanent financing source for health care reform. Once the system is made more efficient, we will need to identify more lasting funding sources for the public cost of health care delivery," close quote.

My question is: does the AARP support financing the President's health care plan with $123 billion in cuts to the Medicare program?

Mr. SHREVE. Well, as I alluded to earlier, Mr. Greenwood, I guess you were not here, the—we are concerned about those reductions because every time, as I have indicated, every time there is a reduction in the Medicare program, the people that we represent indicate to us that there is an increasing problem of reduced access, that the money that is listed, the $123 or $124 billion, depending upon, I guess Mr. Vladeck this morning was using $124 billion as the number, that money, if it is truly for reforming the system, we would be much more willing to see that happen, you know, for that reason.

Mr. GREENWOOD. Let me interrupt you for a second. I appreciate the distinction you are trying to make. The problem is when we go to the House Floor, we have a yes button and a no button. We don't have a "Yes, but concerned only if it goes like this."

The next time we confront your members in an election, they will either be angry with us because we voted for those cuts, or they will be annoyed with us because we didn't vote for the health care program. We can't have it both ways, so I am not going to let you have it both ways.

Mr. SHREVE. Well, I think, Mr. Greenwood, you are really focusing on the dilemma that we have as an association, and it is truly a very serious problem.

Mr. GREENWOOD. So what is AARP's official position? Is it yes, it is OK with us? Is it, we have some concern but, yes, go ahead and do it?

It is all right if you reserve your concern. We all have that. But are you saying, go ahead and take the $123 billion cuts in Medicare because we are behind you when you do that?

Now, we have got some concerns about how it comes up, but we are behind you. Or are you saying, don't do that unless we give you a green light at some later date?

Mr. SHREVE. Well, we have not taken a position as a board, and as you know—and I am not trying to waffle, I am only one member of that board.

But as a board we have not yet taken a position on the details of the President's plan. We have not taken a position pro or con, and so this discussion that we are having is something that our board will also have in the near future.

Mr. GREENWOOD. So you are going through this internally. Hopefully, for all of our sakes you will have to cast votes in your subcommittee or committee or elsewhere, and we will at least know whether we are running afoul of your organization or not.

Let me turn to another question if I may. In your testimony you state that, AARP, quote, "Supports the President's proposal to retain and strengthen Medicare rather than dissolve it or force beneficiaries into State-based alliances," close quote.

I am puzzled by that statement because it is my understanding as the AARP statement later points out, that the bill permits, with HHS approval, States to integrate classes of Medicare beneficiaries into the alliances at either the alliance or the State level.

For example, a State could decide to integrate all of the Medicare beneficiaries who are over 65 and living in a particular alliance's area into a regional alliance. Once these beneficiaries are integrated into the alliance, Federal payments are capped at essentially the CPI level.

Further, it is my understanding that the individual beneficiary has no choice in the matter.

So, again, exactly what is AARP's position on this, if you have one now?

Mr. SHREVE. There again, we haven't reached a consensus on the—all the details of the bill or the plan, I should say, rather than the bill.

The concerns that we have are that if there are State plans that do take people into those alliances, as Medicare recipients going into those plans, our concern is that the State knows exactly how to handle those kinds of situations, and in some respects, I think Medicaid is a good example of something where there is certainly no uniformity among States in how Medicaid people are handled,

and we are concerned about Medicare recipients going into that same—that kind of a situation on a State-by-State basis.

Mr. GREENWOOD. OK, thank you, sir.

Mr. SHREVE. Thank you.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Brown, I want to recognize you, but I do want to point out to the members that—to Dr. Shreve that some of the members weren't here for your testimony because we rearranged the schedule to accommodate your schedule.

Mr. SHREVE. I appreciate it.

Mr. WAXMAN. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I just have one question.

You mentioned in your written testimony, Mr. Shreve, that preventive benefits are not currently available to beneficiaries, and that these benefits should be included during the health care reform plan—in the health care reform plan.

We have talked about flu shots and mammography screening. What else should we do about that?

Mr. SHREVE. Well, there are a number of things that come under the heading of preventive medicine or various kinds of screening that could be useful and cost effective if money that is spent up front to identify or to treat things before they become more difficult to treat, and that is the kind of thing that we are looking at.

Right now there is very little that is covered under Medicare that is—would be classified as preventive medicine.

Mr. BROWN. Have you made a proposal specifically what should be included?

Mr. SHREVE. It was not—it is not included in our testimony, but if you would like, we can certainly send you some specific kinds of information.

Mr. BROWN. That would be helpful if you would do that.

Mr. SHREVE. All right.

Mr. BROWN. How would Medicare managed care programs be—what would be the impact on them if Medicare benefits were to include preventive benefits? How would that play one against the other?

Mr. SHREVE. I think that would be useful if that were included in the managed care program. I think that would be a positive thing.

Mr. BROWN. That is all, Mr. Chairman.

Thank you.

Mr. WAXMAN. Thank you, Mr. Brown.

Thank you very much, Mr. Shreve, for your testimony.

Mr. SHREVE. Thank you, Mr. Chairman.

Mr. WAXMAN. I am pleased to call forward Dr. Paul Ginsburg, Executive Director of the Physician Payment Review Commission. The PPRC provides analyses and advice to the Secretary of HHS and Congress on Medicare payment policies for physician services.

Dr. Ginsburg, we want to welcome you back to our subcommittee. We appreciate your participation in today's hearing. Without objection, your full statement will be made a part of the record.

We would like to ask you to limit your oral presentation to 5 minutes.

STATEMENT OF PAUL B. GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. GINSBURG. Thank you, Mr. Chairman.

I am pleased to come before you again to testify in behalf of the Physician Payment Review Commission, this time on the Medicare sections of the President's proposal for health care reform.

I can report to you the commission's thinking regarding some of the Medicare initiatives and others, I must await our next meeting. I will begin with some comments on Medicare cuts in general and then go into some of the specifics.

The proposed cuts must be seen in the context of successive Medicare payment reductions in recent years. The Budget Acts of 1990 and 1993 and the implementation of the Medicare fee schedule have had a substantial cumulative impact on Medicare payment rates to physicians, increasing the gap with what private insurers pay physicians.

The experience with Medicaid serves notice that fee reductions beyond some point can interfere with access to care. The commission has for years been analyzing data from private insurers and noting the decline in Medicare relative payment rates. We estimate that on average, in 1993, Medicare rates are 60 to 65 percent of the private rates on average.

The commission has been monitoring Medicare access in various ways. Data from early 1992, the period of initial implementation of the Medicare fee schedule, did not reveal any significant deterioration in access, though it did show longstanding problems for some vulnerable populations.

We are now preparing data from the first half of 1993 for analysis and will report any significant findings to the committee as these studies are completed.

The effects of the combination of Medicare cuts with increased constraint on private payers are difficult to project. In general, it is likely that Medicare cuts would cause fewer dislocations for beneficiaries if carried out against a backdrop of significant constraint by private payers.

Turning to the specific savings proposals, the changes in the Medicare volume performance standard appear to be consistent with past positions of the commission. If I am interpreting the provision correctly, the change to a cumulative basis to calculate the performance standard is a positive one, as is the replacement of an expenditure baseline and performance standard factor by the trend of gross domestic product.

The commission advises against the proposed changes in relative values. These changes depart from the resource basis of the Medicare relative value scale and would undermine its credibility. If the Congress desires to favor primary care services further, it should focus on the conversion factors instead.

Nevertheless, I want to point out that the Congress has already taken a number of important steps to increase the relative payment for primary care services.

Before proceeding further, we need to take stock of how far we have gone and whether further changes would go too far. The commission has not yet discussed the proposal for prohibiting balanced billing in Medicare. I do want to relate to you, however, the long

and difficult process that the commission went through in 1988 and 1989 to arrive at its recommendation to limit but not prohibit balanced billing.

I know that the Congress also struggled with this and that current policy of a 15 percent limit represents one of the key compromises behind the Medicare physician payment reform.

That completes my oral remarks. I would be pleased to answer any questions.

Mr. WAXMAN. Thank you very much, Mr. Ginsburg, for your testimony, and also for your willingness to let Dr. Shreve go in your place so we could accommodate his travel schedule.

[Testimony resumes on p. 443.]

[The prepared statement of Mr. Ginsburg follows:]

STATEMENT OF PAUL B. GINSBURG

Mr. Chairman, I am pleased to come before this committee to discuss Medicare and health care reform. Since it was established by the Congress in 1986, the Physician Payment Review Commission has devoted a major portion of its work to issues related to physician payment under the Medicare program. We began by assisting the Congress in shaping the Medicare reforms enacted in 1989 and since then have been monitoring the implementation of those reforms and developing refinements in the policy.

My testimony today will focus on changes in fee-for-service Medicare to finance reform and to promote primary care. The Commission has recently begun work on the issue of enrollment of Medicare beneficiaries in regional alliance plans, and when that analysis is further along, we will be pleased to share our findings with the committee.

Medicare Cuts: Broad Perspective

The Commission has begun to combine Medicare and private sector data to determine the implications of payment changes for access to care, since the information available to date is not conclusive. The history of the last decade has been one of significant restraints on Medicare outlays played out against a backdrop of increasing fee levels paid by private insurers. The growing disparity between Medicare and private payment rates is surely one caution against further reductions in Medicare Part B spending growth through constraint on payment rates. Initiatives to reduce Medicare spending might be more successful, however, if done in tandem with changes that will restrain private sector reimbursements.

The effects of recent legislation aimed at reducing Part B expenditure growth are still being felt. The Omnibus Budget Reconciliation Act of 1990 (OBRA90) included a broad round of fee reductions in 1991, affecting almost all services other than primary care. These fee cuts and other reductions were projected to reduce Part B spending by nearly $14 billion over the period 1991 through 1995, roughly a 5 percent reduction below baseline. OBRA93 included decreases in the default conversion factor update, fee reductions for procedures with large practice cost payments, and reductions in payments for lab tests. Projected savings from these cuts amount

to $15.6 billion over the period 1994 through 1998, or roughly a further 4 percent reduction from baseline projections.

These savings estimates do not reveal the full extent of payment rate reductions because a 50 percent "volume offset" is factored into both the Congressional Budget Office (CBO) and Health Care Financing Administration (HCFA) savings estimates. Each dollar of projected savings reflects roughly two dollars of fee reductions because CBO and HCFA assume that physicians offset half of any cuts by billing increased volumes of care to Medicare. For example, the 6.5 percent fee reduction that accompanied the introduction of the Medicare Fee Schedule was scored for no savings at all because the fee cut was to offset an expected increase in volume of care. Analysis in the Commission's 1993 report to Congress shows that the actual volume offset was significantly lower than the 50 percent, so that actual savings (and the actual impact on physicians' revenues) has been larger than projected.[1]

These reductions have significantly widened the gap between the fees paid by Medicare and private insurers, both Blue Cross and Blue Shield (BCBS) plans and commercial insurers. In 1989, Medicare fees averaged 79 percent of Blue Cross and Blue Shield fees. By 1991, this had fallen to 72 percent, with BCBS fees growing 3.3 percent per year while Medicare fees fell 1.2 percent per year. By 1993, the ratio of Medicare to BCBS fees is projected to have fallen well below 70 percent. The contrast with commercial insurers is even more dramatic, with 1991 Medicare rates averaging less than 60 percent of commercial rates. The gap for specific procedures such as coronary artery bypass graft or gall bladder removal is wider still, with 1991 national average Medicare fees typically between 30 and 40 percent of the national average fee paid by private insurers.

Such large and growing differentials in payment rates raise the possibility of problems in access to care. Evidence from the Medicaid program serves as a warning that fee reductions beyond

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[1] Because of this, and also reflecting an economy-wide slowing of health care expenditure growth, Medicare Part B outlays rose roughly 4 percent in 1992, versus a projected growth of more than 10 percent. Preliminary data from FY 1993 show a similarly low rate of outlay growth.

some point can interfere with access to care. The Commission is currently monitoring Medicare beneficiaries' access to care to attempt to determine where that point might be. Returns from early 1992 showed no significant deterioration in access just after introduction of the Medicare Fee Schedule. (There were, however, evident access problems for disadvantaged populations that pre-dated the recent round of reductions.) The Commission is now examining additional sources of information, including Medicare 1993 claims data, formal surveys of beneficiaries and physicians, and informal surveys of beneficiaries' complaints regarding access to care. In addition, the Commission is cooperating closely with the American Association of Retired Persons to identify areas in which Medicare beneficiaries are currently having difficulty finding a physician. The Commission plans to present findings from this research in its 1994 report to the Congress and its 1994 report on access to care, but will communicate any significant findings to the committee as these studies are completed.

While the Commission cannot draw firm conclusions on how the Administration's proposed health care reform will affect the interaction between Medicare budget reductions and access to care it can consider alternative scenarios. Private health plans will be placed under more intensive competitive pressure, and may be subject to premium caps. Alliances will negotiate fee schedules for all fee-for-service providers, probably increasing the financial stress on these providers as well.

Under one scenario, this private sector restraint may tend to crowd Medicare patients out of physicians' offices. Reduced payments may spur physicians to keep only the most remunerative private sector patients, or may encourage physicians to boost the volume of care provided to those patients, leaving less time to care for the relatively less-profitable Medicare beneficiary. However, the Medicare Volume Performance Standard (VPS) mechanism provides some degree of stabilization to this process, because Medicare fees will automatically rise if growth in the volume of care delivered to Medicare beneficiaries slows.

On the other hand, successful private sector efforts to restrain fee growth may reduce the gap between Medicare and private sector fees, lessening the financial gains from concentrating solely

on private sector business. Moreover, if various types of managed care organizations lead to more efficient practice patterns, this may spill over positively into the Medicare program: the resulting lower rates of volume growth would not only benefit Medicare beneficiaries due to the increased appropriateness of care, but would, through the VPS mechanism, lead to higher Medicare fee updates.

Predicting the impact of further Medicare cuts on Medicare beneficiaries' access to care remains a challenge for the Commission and the Congress. In general, however, it seems plausible that Medicare will have an easier time constraining expenditures if that is done against a backdrop of significant constraint in the private sector. Medicare access will probably be less likely to suffer from budget cuts if such cuts are made in concert with private sector reform so that Medicare does not become an increasingly poor payer relative to the private sector. At the same time, there is the risk that further Medicare cuts can be implemented more rapidly than the private sector can respond to constraints imposed under system reform, exacerbating the imbalance between Medicare and private sector payment levels at least in the short term.

Volume Performance Standards

The Administration has proposed a series of revisions to Medicare Volume Performance Standards. One revamps the calculation of the component of the performance standard that allows for increasing volume and intensity of services. Instead of extrapolating past trends of volume and intensity growth and subtracting a performance standard factor (OBRA93 sets this to 4 percentage points for years beginning with fiscal year 1995), the proposal would base the volume and intensity component on the trend of real gross domestic product (GDP).[2] Another change removes actual levels of spending from the base used to calculate the annual performance standard. Instead the base would reflect previous years' performance standard factors. Finally, the limitation on how much could be subtracted from the Medicare Economic Index (MEI) under the conversion factor update default would be removed.

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[2] This amount would be increased by 1.5 percentage points for primary care services.

Although the Commission has not yet had an opportunity to discuss fully these specific changes, I can provide substantial insight into its reactions on the basis of our previous recommendations to the Congress. The Commission has used real GDP growth as a guide for establishing the volume and intensity component of the performance standards it has recommended to the Congress each year. The Administration's proposal is consistent with that approach. In essence, it alters the determination of performance standards from one of how much should be subtracted from the baseline growth in spending to one of how much can society afford to spend. I should note, however, that the Commission has added a factor to reflect the more rapid growth in the number of Medicare enrollees than in the general population.

From a technical perspective, changing the base used to calculate the performance standard to reflect previous years' standards appears to be sound. It would correct the deficiency of the current mechanism that has permitted actual spending (whether above or below the performance standard) to affect the performance standards for future years. This has diluted incentives somewhat and impaired the Congress' ability to budget spending for physicians' services. My tentative support for this provision is based on the explanation of the provision given to PPRC staff by HCFA officials, but not on how the provision is currently drafted in the Health Security Act.

The Commission took up the question of increasing the maximum reduction in fee updates when reviewing the President's budget proposals for fiscal year 1994. Under the default formula for updating the conversion factor, the update is determined by subtracting the difference between actual expenditure increases and the performance standard from the Medicare Economic Index. Limitations have been placed on the maximum amount that could be subtracted, however. ORBA93 increased the allowable reduction from 3.0 percentage points to 5.0 percentage points beginning in 1995. The Commission supported this change while noting that an increase over 5.0 percentage points would be too high. While it has not taken up the issue of eliminating the maximum reduction, given its previous position, the Commission may not support such a policy. The Commission also has recommended that limits on adjustments in the MEI should be

symmetric -- that it would be appropriate to have the same limits on the amount that can be added to the MEI as apply to the amount that can be subtracted.

The President's plan also proposes limitations on payments for physicians' services provided by high-cost medical staffs. The Commission has just begun to examine this option and will share the results of that analysis with the committee as the work proceeds.

Promoting Primary Care

The President's health care reform proposal contains several provisions to promote primary care. They focus on increasing relative values for primary care services to further the policy objective of increasing payment for those services. Those increases would be paid for by reducing payment rates for nonprimary care services. The initial relative values for the Medicare Fee Schedule were derived from the research of Professor William Hsiao and his colleagues at Harvard University. Relative values for the work component were based on physicians' estimates of the relative work required to provide each service. Over time, HCFA has refined the relative value scale using methods, such as structured expert panels, designed to ensure that relative values reflect as accurately as possible the actual work involved in performing a service.

Retaining and strengthening the resource basis of the relative value scale ensures appropriate incentives for decisions about which services to provide to a patient, as well as acceptance by the medical profession. The integrity of the relative value scale will be even more important in the future as Medicare relative values become more broadly applicable to other payers.

For these reasons, the Commission would advise against the changes in relative values included in the President's health care reform proposal. Although designed to promote the delivery of primary care services, one of the fee schedule's principal goals, these changes would depart from the resource basis of the relative value scale and thus would undermine the credibility of the Medicare Fee Schedule. In considering this issue, the Commission recommended in its *1993 Annual Report to Congress* that changes in work values be directed towards calibrating

them as closely as possible to work. Policy goals, such as encouraging primary care practice, should be effected through other mechanisms (such as bonus payments) rather than by manipulating relative values.

Beyond the Commission's general objection to changing relative values to achieve policy goals, it has specific concerns about several of the proposals included in the Administration's health reform plan. These are described in more detail below.

The plan proposes a reduction in relative values for office consultations to make them equal to those for comparable office visits. The resulting savings would be used to increase fees for all office visits. But the current average work intensities (relative value units per minute) of office consultations and office visits are already nearly identical; in fact, the Commission's past work has suggested that consultative visits should have higher work intensities than nonconsultative visits. Moreover, if the rationale is that payments for consultations are too high, it is curious why payments for hospital consultations were not similarly slated for reductions.

Second, the plan proposes increasing the relative values for office visits by 10 percent to reflect time spent before and after visits. The rationale appears to be that time spent before and after visits (so-called pre/post time) is not fully accounted for in the relative values. This is directly contrary to the Commission's conclusion, based on its visit survey, that the Hsiao study systematically over-estimated pre/post time for visits and consultations. Unless it could be demonstrated that there was a systematic error in the other direction in the Hsiao study, arbitrarily increasing office visit relative work values by 10 percent would violate the resource basis of payment.

Third, the Administration also proposes further refinement of the fee schedule by reducing relative work values of procedures for which the average work intensity differs considerably from that of services that are thought to be of comparable intensity. Using work intensities to identify overvalued services may be a useful component to the refinement process which to date has focused primarily on undervalued services. The Commission is troubled, however, by plans to

apply any savings to the work component for primary care services. Again, this would further distort the relationship between primary care and other services. Use of other policies such as bonuses to enhance primary care payments could achieve the same goal while not departing from the resource basis of the fee schedule.

The Administration proposal also calls for the implementation of a resource-based methodology to determine relative values for the practice expense component of the Medicare Fee Schedule beginning in 1997. This is consistent with the Commission's recommendations to base the practice expense component of the fee schedule on resource costs. The proposal would also increase practice expense relative values for primary care services by 10 percent in 1996. While this type of transitional policy would be generally consistent with the direction of reform, some practice expense relative values would likely be raised above the levels expected under full implementation of a resource-based practice expense methodology. Moreover, because physicians do not incur all the costs of providing services in non-office settings, an approach that would increase practice expense relative values for primary care services regardless of site has a particularly troublesome potential for overpayment for services provided in nonoffice settings (for example, emergency departments; nursing homes).

Finally, the Commission has concerns that the cumulative effect of the Administration's proposals to promote primary care practice, when combined with recent policy changes, may move payments beyond what was contemplated when the Medicare payment reform was enacted. Congress has already taken a number of steps that will make primary care more attractive. These include establishing a separate performance standard for primary care, phase-in of resource-based relative values for the practice expense component of the Medicare Fee Schedule, and exemption of primary care services from general update reductions. While these steps are well advised, particularly given the higher updates for surgery in recent years threatening to undermine anticipated gains for primary care, additional efforts may tip the balance too far.

Bonus Payments in Health Professional Shortage Areas

The Administration's health reform proposal would increase the Medicare bonus payment for primary care services delivered in urban and rural health professional shortage areas (HPSAs) from 10 percent to 20 percent. It would also eliminate the bonus payment for nonprimary care services delivered in urban HPSAs.

The effectiveness of the bonus payment in providing financial incentives for practice in underserved areas and improving access to care has long been of interest to the Commission, and we are currently weighing a number of options to strengthen the program with the goal of developing recommendations for our March report. Although decisions will not be made until the Commission's December meeting, recent analysis of Medicare claims has shed new insights on the policy's performance. In rural areas, the program appears to target primary care physicians, primary care services, and physicians treating vulnerable populations. Physicians receiving bonus payments in urban HPSAs also are more likely to treat members of vulnerable populations than the typical physician in urban areas. But the bonus payments are not as well targeted in urban as in rural HPSAs; primary care physicians receive only about one-third of bonus payments and only about one-quarter of bonus payments support primary care services. A particular concern is that specialists providing hospital-based services in urban HPSAs may receive bonus payments for treating beneficiaries who live outside shortage areas.

The Administration's proposal would more effectively target the policy on primary care services. There are certain risks, however, associated with this approach. While support for primary care is essential to improving both health status and entry into the health care system, beneficiaries in urban HPSAs also have needs for surgical and specialty services. Eliminating the bonus payment for these services may detract from the program's ability to influence physician location decisions. In addition, limiting the bonus payments to primary care services as legislatively defined would eliminate nearly three-quarters of the bonus payments distributed in urban HPSAs if the bonus remained at 10 percent. Even if the limit were implemented in conjunction with an increase in the bonus to 20 percent, as contemplated in the President's proposal, primary care

physicians, whose practices in urban HPSAs were found to be composed of approximately 43 percent primary care services, would receive slightly less in bonus payments than they do now.

Constraints on Extra Billing

In its design of the fee-for-service options that will be available under health care reform, the Administration has proposed that physicians not be permitted to charge above the alliance fee schedule amount. This policy would also extend to the Medicare program, which currently permits physicians to charge 15 percent above the fee schedule amount. One rationale for this proposed policy would be to ensure that Medicare beneficiaries receive the same financial protection as other patients.

The Commission considered this option in its design of Medicare physician payment reform but rejected it in favor of balance billing limits. This decision was based on a judgment that the market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without such limits, the Commission feared that costs would increase and access would suffer. At the same time, the Commission viewed some allowance for balance billing as a safety valve to ensure that physicians who did not perceive Medicare fees as adequate would continue to treat Medicare patients. In addition, no matter how much care is taken in developing and refining the fee schedule, there were concerns about those instances in which prices do not precisely reflect resource costs, or where sudden changes in technology result in increased costs for a procedure that cannot be immediately incorporated into the fee schedule.

The Commission and its staff are prepared to continue to work with you on these and other issues related to health care reform. I welcome any questions you may have.

Mr. WAXMAN. I want to start off by indicating I have serious reservations about the magnitude of the proposed reductions in Medicare payments called for in the President's plan.

In your testimony, you present some very dramatic data about the growing disparities between what Medicare pays for services and what private plans are paying. You state, and I quote, "Such large and growing differentials in payment rates raise the possibility of problems in access to care evidenced from the Medicaid program serves as a warning that fee reductions beyond some point can interfere with access to care."

While you go on to say that early returns from your monitoring of beneficiary access show no significant change, I gather you do have some less systemic evidence of increased patient complaints.

Can you share with us how you are going about monitoring access to care, whether you think the Medicare cuts proposed in the President's plan are adequately coordinated with the transition to universal coverage?

Mr. GINSBURG. Yes, we are monitoring access to care in a number of complementary ways. First, we are analyzing the claims data that we get from HCFA to see instances of whether certain rates of service use have declined, especially in those areas subject to the deepest cuts.

In addition, we have been serving physicians asking them about their policies with regard to accepting new Medicare patients, and the results for 1992 were very encouraging that this has not been a problem, but we are awaiting the results for 1993.

In addition, we are analyzing the current beneficiary survey that HCFA conducts. This will be the first year that we will have a before and after comparison of the Medicare fee schedule, and finally, we have been working with AARP which put a notice in its Modern Maturity magazine with a questionnaire to beneficiaries about whether they have had any problems seeing a doctor through the Medicare program.

You also asked about the coordination between the changes affecting private plans and the Medicare cuts, and in the physician area, I don't see the coordination in the sense that the physician payment cuts begin right away and the implementation of the health care reform in many States could be as late as 1998.

So we could have a gap of a number of years where we are further squeezing payment rates before at least the full pressure by the private payers takes effect.

Mr. WAXMAN. Your statement discusses the PPRC's position on balanced billing limits in that the commission views the opportunity for physicians to balance bill patients as a safety valve to insure that physicians who did not perceive Medicare fees as adequate would continue to treat Medicare patients.

My question is whether the commission, in light of the ban on balanced billing by physicians in both private plans and Medicare under the President's proposal, would continue to oppose this policy.

Do you think a 15 percent safety valve would be desirable under the fee schedules that would apply to private plans offered by an alliance, and would it be wise to just prohibit balanced billing for

people who are eligible for the low income subsidies under the plan?

Mr. GINSBURG. There certainly is a lot of merit to having a consistent policy between the private fee schedules and the Medicare fee schedule and, as you say, we need to consider whether there should be a limited amount of balanced billing allowed for in the private fee schedules. The commission hasn't discussed this. It will at its next meeting.

On the issue of having balanced billing only for—I mean balanced billing only for those not of low income, the commission has discussed this on various occasions in the past and has always been against that, feeling that this could really compromise access to care for low income persons.

Mr. WAXMAN. So again, it is just having low income people be the only ones who would have it?

Mr. GINSBURG. Yes, that is right.

Mr. WAXMAN. Thank you very much.

Mr. Greenwood, I want to recognize you. Do you have questions you want to pursue?

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Ginsburg, the Clinton health care plan prohibits balanced billing for all Medicare beneficiaries. AARP's testimony notes its strong support for this provision. In your view, will this prohibition help or hurt Medicare beneficiaries?

Mr. GINSBURG. That is a good question. I would imagine that this—I mean this provision will help some beneficiaries, will save them some money, but I would be concerned that for some it will be the difference between good access and more limited access.

I think for this—this could be the difference for some physicians in their willingness to see Medicare beneficiaries in large numbers.

Mr. GREENWOOD. How much do we know about that phenomenon, what if you stop balanced billing and there is no measurable change in access? Who has studied that and what do we know about that?

Mr. GINSBURG. I don't think we have had any experience where a program has gone from, say, balanced billing to no balanced billing. But in the Medicare program of course we have gone from the experience of unlimited balanced billing to limited balanced billing, and from what we can see, that has not caused a problem in access.

Access remains good and we haven't noticed any deterioration, at least through 1992.

Mr. GREENWOOD. Haven't States taken actions in their Medicaid programs? When I was in the Pennsylvania legislature, it seems to me we passed what was called the Mom bill which was hard to vote against. It was the Medicaid overcharge measure.

Have we looked at the States? Are you aware of studies that have looked at States to look at the——

Mr. GINSBURG. Well, we know that in many States, that access to physicians by Medicaid beneficiaries is not very good. Medicaid I believe has always had a prohibition on balanced billing and in many States has very low fees, so certainly the combination of the two has meant that some physicians just make very little, if any of their time available to see Medicaid beneficiaries.

Mr. GREENWOOD. One of the things that we learned as we held hearings on that measure that I just mentioned was that you get very different results when you apply the balanced billing prohibition to primary care physicians, who you may want to come out to nursing homes and places like that versus the impact it has on the surgeons, anesthesiologists and so forth. I think we were trying to exempt some internists and some family physicians and maybe other primary care physicians.

Are you of the opinion that if we wanted to be conservative on the side of making sure that we take the least risk of limiting access, that it might make some sense to draw a line within the specialties?

Mr. GINSBURG. I think with our previous payment system, it might have made some sense, in the sense that with procedural services so much better paid than primary care evaluation management services, that it seemed as though—it might be more constraining on what physicians charged for the procedural services, you risk less as far as reduction of access.

Now, of course with the Medicare physician payment reform phasing in, we have a very different structure of payment. So I think the merits of distinguishing by specialty are probably much less now than they were before.

Indeed I am pleased to report that significant numbers of Medicaid programs have changed their physician payment system to use the Medicare relative value scale, and thus have the same structure of relative payments as the Medicare program has had.

Mr. GREENWOOD. OK, I think we have just gotten into the other question I was going to ask you, so I yield back the balance of my time, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

The Medicare volume performance standard, the question about that, how will that, if you could sort of lay out for me, what kind of impact will that have on physician practice? How will the changes in the MVPS formula—if you could sort of spell those out for us.

Mr. GINSBURG. Sure. I am not sure that the changes in the formula would have much of an effect on physician practice. I think one of the concepts behind the MVPS is the notion that this puts physicians as a group at risk for their—the volume of services that they prescribe and deliver.

In a sense that if a service volume increases rapidly, this is going to mean slower increases or even fee reductions for physicians. I think that basic incentive is in place under the existing volume performance standard and it would remain under the new system.

I see the changes proposed by the President for the volume performance standards as being one of generally tightening it, in a sense setting lower performance standards, and this generates budget savings, and also another aspect of doing some technical refinements to it.

I think there were some problems with the mechanism in the sense that spending under the volume performance standards, say for this current year, whether it is low or high, eventually gets

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factored into the baseline for future performance standards, so that was a problem that the—I believe the proposed change would resolve.

Mr. BROWN. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. WAXMAN. Thank you, Mr. Brown.

Dr. Ginsburg, thank you very much for your testimony. We look forward to working with you on all these issues.

Our next witnesses include representatives of entities that provide health care services, Richard Pollack is the Executive Vice President of the American Hospital Association, Val Halamandaris is the President of the National Association for Home Care, and Hope Foster is General Counsel to the American Clinical Laboratory Association.

We welcome you to our hearing today. Your prepared statements will be in the record in full. We would like to ask you to limit your oral presentation to no more than 5 minutes.

Mr. Pollack, why don't we start with you.

STATEMENTS OF RICHARD POLLACK, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; VAL J. HALAMANDARIS, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE; AND HOPE FOSTER, GENERAL COUNSEL, AMERICAN CLINICAL LABORATORY ASSOCIATION

Mr. POLLACK. Thank you, Mr. Chairman. I am pleased to be here today on behalf of America's hospitals to discuss the treatment of Medicare in the context of health care reform and before I even start, I just want to applaud you, Mr. Chairman, for both your dedication to achieving the health care reform plan that will provide universal access, and for your continued leadership in ensuring that Medicare continues to meet its commitment to the elderly.

We want you to know that you have our strong support on both of those things and we stand behind you. I would like to make two points today. First in regard to the Medicare budget reductions of the $125 billion in Medicare reductions that we now see are in the President's plan, approximately $79 billion of that comes from hospitals.

These reductions are both unprecedented and unwise and could cause serious harm in many places, which is why we are so strongly opposed to them.

According to the Prospective Payment Assessment Commission's own figures, over two-thirds of the Nation's hospitals are being reimbursed only 88 percent of their costs for Medicare services on average, and I might add that that is data that is 2 years old, so the situation is worse today and further reductions will only exacerbate it.

The bottom line, putting pressure on the infrastructure of the health care system when we are trying to rebuild it is nothing short of irresponsible, and we would be pleased to discuss specifics on why that is the case.

Even more significantly, not only is this all just business as usual in terms of arbitrary cuts that are not designed to fix what is wrong with the system, but it comes on top of some very signifi-

cant cuts that were enacted just 3 months or 6 months ago, $56 billion in OBRA 1993 and $43 billion in 1990.

We must recognize that the Medicare payment system is broken and it is full of incentives for volume growth which just increases cost. Providers continue to get paid on a piece work basis for each medical encounter and the only incentive is to generate more and more pieces on medical encounters.

Moreover, the reductions proposed do nothing to address the overcapacity problems that Mr. Vladeck alluded to. If we are to achieve further efficiencies in the Medicare program, our best hope is to provide care through a reorganized delivery system, and accountable health plans which are locally based, paid on a capitated basis and held publicly accountable to their communities have the potential to be the integrated delivery systems or community care networks that we believe should be the foundation for a restructured delivery system.

The second area I would like to address is how Medicare is treated in the context of a new delivery system. We believe that leaving Medicare out of the new delivery system constitutes a half-hearted attempt at reform, particularly when you consider that the program comprises nearly 40 percent of an average hospital's revenues.

Leaving the program out of the new system gives providers conflicting incentives. For Medicare, a hospital would be under the old system. For Medicaid and the private sector, it would operate in the new world of health purchasing alliances and accountable health plans.

Let me just give you an example. If you are a hospital that is a high Medicare volume provider, say 50 to 60 percent of your revenues are from Medicare patients, that is not uncommon. The pressure will be enormous because the hospital will be severely underfinanced for the services it provides to these vulnerable populations.

And just think about the new world under reform where hospitals are given a choice of either being a partner, developing an accountable health plan, or being a vendor of services to an accountable health plan. Under these circumstances, continued under funding on a significant portion of services in terms of the high Medicare volume piece will make it very difficult for the hospital to either be a partner in being an accountable health plan, or it will make it very difficult for them in being a competitive bidder in providing services to the plan.

In conclusion, we think that the significant point here is that if we must achieve further efficiencies in the Medicare program, particularly for the purpose of keeping the trust fund viable for our parents and grandparents, not to mention for ourselves and our kids, that can only be done by providing Medicare beneficiaries with services through a more efficient delivery system.

Mr. Chairman, thanks again for giving us the opportunity to share our views. We look forward to working with you and other

members of the committee, and we would certainly be pleased to answer any questions you may have.

Mr. WAXMAN. Thank you very much, Mr. Pollack.

[Testimony resumes on p. 463.]

[The prepared statement of Mr. Pollack follows:]

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**Statement
of the
American Hospital Association
before the
Subcommittee on Health and the Environment
of the
Energy and Commerce Committee
United States House of Representatives
on
Medicare and Health Care Reform
November 18, 1993**

Mr. Chairman, my name is Rick Pollack, executive vice president of the American Hospital Association. On behalf of AHA's 5,300 institutional members, I am pleased to testify today on proposed Medicare spending reductions and the integration of Medicare into a reformed health care system.

THE TIME FOR REFORM IS NOW

America's hospitals believe that now is the time to reform our health care system. President and Mrs. Clinton raised the curtain and put reform under the national spotlight. You and the members of your subcommittee have played -- and will continue to play -- a valuable role in making reform a reality. But, our time in the spotlight is often fleeting, and if we don't act now, another opportunity to reform health care may not appear for decades.

In acting promptly, we must not act unwisely. In our zeal to build a better health care system, we must keep our eyes on the long-range goal of creating a reformed health care system that efficiently serves all Americans. Purely budget-driven decisions can make our nation's health-care problems worse, and can stall the drive toward effective reform.

If we want to achieve fundamental, workable reform, two things are clear. One, we should not be taking big chunks of resources out of a program -- Medicare -- that must be part of the foundation of reform. And two, Medicare must operate under the same reform principles as the rest of the health care economy.

MEDICARE REDUCTIONS

The Administration's proposed reductions of $125 billion in future Medicare spending would chip away at the foundation of care for America's elderly. Such unprecedented reductions would be unwise policy anytime, but would be especially dangerous as we attempt to reform our health care delivery system. In addition, the effects of these reductions would be compounded by the $56 billion already cut from Medicare in the last budget round -- on top of $43 billion included in the Omnibus Budget Reconciliation Act (OBRA) of 1990.

Based on the only information available to date, about $100 billion of the Administration's proposed $125 billion in total Medicare reductions would come from lower payments to providers -- and $79 billion of that would come from hospitals. We certainly agree with the nation's need to slow health care spending growth. And, we support the added benefits

intended for Medicare patients -- prescription drugs and long-term care. But, we cannot support underpaying hospitals in order to pay for these benefits.

Providing universal coverage is not cost-free. Expanding the covered population, restructuring the health care system, reconfiguring hospitals and other services for the future, and investing in new technologies to meet the demands of the new system -- all will need adequate resources. For example, the infrastructure improvements we all endorse in order to reduce administrative costs -- electronic billing, computerized patient records, new information systems -- require an up-front investment. Reaping the benefits of these efficiencies will not happen overnight. But they will never materialize if we don't invest adequate resources now.

Hospitals are key to the health care infrastructure. In building upon that infrastructure, we should not weaken its foundation. Furthermore, hospitals' ability to get beyond the traditional hospital acute care role that will be necessary under reform would be jeopardized by excessive spending reductions. For example, consumer education, wellness, and outreach programs -- not funded by the current system -- are among the most vulnerable when finances are squeezed.

OBRA 1993 reductions compound the problem

It is also important to remember what happened earlier this year in OBRA 1993 (P.L. 103-66) -- $24 billion of the $56 billion in Medicare reductions came from hospital care for the elderly. Most of these reductions will take effect in the out-years of 1996-1998. Stripping another $79 billion from Medicare hospital payments adds up to a total of $103 billion in reductions (see

attachment 1). Moreover, the impact grows rapidly in later years. Such a huge alteration in Medicare spending is larger than the hospital community has ever sustained, and is simply too big a risk to take.

Yes, we're concerned about the impact on hospitals. But hospitals take care of people. They exist in communities and are operated by enormously skilled and dedicated people. Particularly hard-hit would be facilities that treat large numbers of low-income patients -- Medicare disproportionate-share hospitals -- that would lose more than $21 billion. Teaching hospitals -- whose mission will be the training of the primary care physicians who are such an integral part of a reformed health care system -- are slated for nearly $17 billion in reductions over five years.

And let's be candid. You can't affect human institutions without affecting human beings in some way. The Administration's proposed Part A hospital spending reductions per Medicare enrollee would total more than <u>$440</u> per individual in the year 2000. That's a 9 percent reduction in Medicare Part A benefits paid <u>per enrollee</u> in a single year (see attachment 2).

In the year 2000, hospitals would have $1,265 fewer dollars <u>per admission</u> to care for Medicare patients -- that's 12 percent less per Medicare admission in a single year. In 1991, overall Medicare payment fell 12 percent short of meeting hospitals' costs for those patients (see attachment 3). That's why two-thirds of the nation's hospitals must subsidize the cost of treating Medicare patients in fiscal 1993. Many of these hospitals are the source of health care for poor,

elderly, and rural Americans. Reduce Medicare resources and you create huge gulfs between payments and costs for these hospitals. This is simply unsustainable.

Just looking at the way hospitals are forced to make up for Medicare and Medicaid shortfalls today should throw up a red flag for the future. Hospitals today must compensate for payment shortfalls by attempting to reduce costs and by raising charges to private-sector patients. But the Administration's plan would limit private sector premium increases -- effectively precluding such cost-shifting in the future.

If private sector premium increases are limited and cost-shifting is precluded, hospitals' ability to compensate for payment shortfalls will be limited -- because their ability to significantly reduce costs in the current delivery system is limited. As the Prospective Payment Assessment Commission recently reported, 60 percent of hospital cost increases from 1985 to 1989 were due to factors beyond hospitals' control -- inflation in the general economy (39 percent) and increasing complexity of patients treated (21 percent) (see attachment 4).

The primary ways in which hospitals can control costs are unpalatable: reduce the size of the hospital work force, or reduce services and programs -- or both. Hospitals are reluctant to reduce their work force, because doing so jeopardizes their ability to do their job well -- hospitals are very labor-intensive facilities. Similarly, it is often easier to eliminate certain services than to restructure services in order to cross-subsidize care. Hospitals will continue to

work to provide care more efficiently. But, given these economic facts of life, additional Medicare payment reductions would be felt more deeply than ever by hospitals.

We should also remember that the Part A trust fund is financed through a payroll tax dedicated to pay for Medicare Part A benefits only. Raiding this trust fund to provide Part B benefits, or to finance a lion's share of broader health care reform, is unwise health care policy as well as unwise federal fiscal policy. Money flowing into this dedicated trust fund finances a specific set of benefits -- benefits that would be threatened if the trust fund is sacrificed to other purposes.

<u>AHA recommendations</u>

What do we recommend? We believe that health care reform should be financed in a broad-based manner. This includes three components:

1) Use the estimated $58 billion in savings and taxes now targeted toward deficit reduction to help finance the health care reform effort.
2) Look for alternative funding sources, such as increasing "sin taxes" and limiting employer/employee tax deductibility for health care coverage. And, because the Administration plan creates new entitlement subsidies for many individuals and small businesses who may be able to afford coverage on their own, savings could be achieved by income-testing these subsidies.
3) Instead of ratcheting down the current volume-driven delivery system, reform the way patients receive care by restructuring the health care delivery system to stimulate both effectiveness and efficiency.

MEDICARE INTEGRATION

This brings me to the second issue that you've asked us to talk about today: the integration of Medicare into a reformed health care system.

What do we mean by integration? We believe it's absolutely essential that the Medicare population be part of the same reformed system as other Americans. It is also essential that providers' incentives are the same, no matter who sponsors a patient's care, to promote more efficient and cost-effective care. Medicare patients account for 40 percent of a typical hospital's revenues. Imagine trying to run an efficient hospital if nearly half of what you do is driven by one set of financial incentives, and the other by entirely different -- in fact, exactly opposite -- incentives. That's a formula for chaos if there ever was one.

But that's just what will happen if Medicare patients remain outside the reform tent. Patients in the reformed health care system will have a financial incentive to purchase coverage from cost-effective providers. And those providers will have an incentive to use services wisely, because inappropriate use reduces the funds available for other purposes. Shouldn't Medicare beneficiaries have strong incentives to seek cost-effective care and their providers have consistent incentives to treat them in the most cost-effective way?

Provider cooperation, integration threatened

For hospitals, this two-pronged approach just doesn't make sense. First, it undermines both the financial and administrative incentives to form the kind of cooperative provider partnerships and networks that will produce more cost-effective care. For example, keeping Medicare

beneficiaries in traditional fee-for-service arrangements with all their conflicting incentives means that demonstrated cost savings that come from paying providers an annual fixed fee to care for an enrolled group of patients just won't happen for this important patient group. Such capitated payment provides incentives for <u>all</u> providers to treat patients in the most cost-effective way. And that means better primary and preventive care that saves us money in the long run.

The two-pronged payment system envisioned in the Administration's plan has another significant flaw. It disadvantages those hospitals serving a disproportionate share of Medicare patients. Given Medicare's historic underpayment record, made much worse by the reductions proposed in the Administration's legislation, these institutions would be severely crippled in their efforts to become part of a reformed health care system. Hospitals with high Medicare volume, for instance, could be financially unattractive to potential partners as local provider networks are formed. And, they simply wouldn't have the resources to do the reconfiguring and outreach that is going to be necessary as we move from today's flawed system to tomorrow's better one.

<u>Changes needed in regional alliances</u>

We are not, however, calling for Medicare beneficiaries to be included in regional alliances. We are concerned about the structure of these alliances -- we feel they are too big and too complex. Plus, they have to work right from <u>Day One</u> of reform -- a tall order for an entity that doesn't even exist today. We would like to see the alliances scaled back to the original concept of purchasing cooperatives for small employers.

<u>Incentives for cost-effectiveness needed for all patients</u>

While we don't advocate including Medicare beneficiaries in regional alliances, we do believe Congress must provide greater incentives for beneficiaries to enroll in the managed care plans currently available under Medicare. Today, fewer than 5 percent of beneficiaries are enrolled in an HMO or other plan that receives a capitated payment from Medicare. Increasing the number of beneficiaries enrolled in capitated plans is important so that providers in those plans will have the same incentives to provide the kind of cost-efficient care that will be required in the restructured delivery system as envisioned by the Administration, the AHA, and others.

We have identified a number of options that we believe could increase enrollment in Medicare managed care arrangements. These include:

Option 1 -- Make managed care arrangements less expensive than a fee-for-service option by waiving a current cost paid by Medicare beneficiaries -- for example, deductibles, copayments, or a limit on inpatient days.

Option 2 -- Offer benefits in a managed care arrangement that are currently excluded from Medicare coverage -- such as prescription drugs, long-term care, or more preventive services.

Option 3 -- Offer a point-of-service option in Medicare managed care arrangements. Today, providers who treat Medicare patients can be paid either on a fee-for-service or a capitated basis. This option give enrollees a third choice: to "opt out" of the capitated payment arrangement, for a single episode of care, at any time to see

a provider of their choice -- but at a higher cost to the beneficiary. This opens to Medicare beneficiaries the same care and payment options currently available to other Americans.

Any of these options must be linked to a vigorous effort to educate older Americans about the advantages of such plans and the satisfaction of those who use them. We see providing incentives for Medicare beneficiaries to choose managed care arrangements as being consistent with the restructuring of the health care delivery system into health plans -- we call them "community care networks.^{sm}" They are the cornerstone of AHA's health reform vision. These collaborative networks would include hospitals, doctors, insurers and other health-care providers. They would evolve over time to provide a broad, coordinated continuum of care with a focus on improving the health of the enrollees <u>and</u> the larger community. In return, networks would be paid a fixed annual fee per enrollee. The allocation of resources among the providers in the network, including the method and level of payment, would be determined within each network.

Such networks would give providers greater freedom to make decisions based on the needs of the community rather than micromanagement by insurers and government-payers. Community care networks would result in a simpler, more efficient, effective, and less expensive system for all Americans -- including Medicare beneficiaries.

CONCLUSION

Mr. Chairman, hospitals, on the front line of health care delivery, feel we also have a place on the front line of reform -- just as you and your colleagues do. We value the working relationship we have built with you on this issue, and we look forward to working with you further as we help build a new health care system for America's future.

Attachment 1

MORE REDUCTIONS IN MEDICARE HOSPITAL SPENDING

PRESIDENT'S PROPOSAL TO REDUCE MEDICARE HOSPITAL SPENDING IS IN ADDITION TO SPENDING REDUCTIONS ALREADY TAKEN IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993)

ANNUAL MEDICARE HOSPITAL SPENDING REDUCTIONS: OBRA 1993 AND THE PRESIDENT'S PROPOSAL FOR HEALTH CARE REFORM
(By fiscal year, in billions of dollars)

	1994	1995	1996	1997	1998	1999	2000	TOTAL
OBRA 1993 [1]	$ 0.8	$ 2.8	$ 5.5	$ 7.0	$ 7.8	$?? [3]	$?? [3]	$ 23.9
CLINTON PROPOSAL [2]	--	--	$ 8.1	$ 11.8	$ 16.0	$ 19.7	$ 23.7	$ 79.2
TOTAL	$ 0.8	$ 2.8	$ 13.6	$ 18.8	$ 23.8	$ 19.7 [4]	$ 23.7 [4]	$103.1

1 Source: Congressional Budget Office

2 Source: Clinton Administration, September 24, 1993

3 The Congressional Budget Office did not estimate the budgetary impact of OBRA beyond 1998. Spending reductions, however, will continue in 1999, 2000 and beyond.

4 Total Medicare hospital spending reductions in these years do not include estimates for the impact of OBRA 1993 (see note above).

Attachment 2

LOWER MEDICARE PART A HOSPITAL PAYMENTS PER ENROLLEE AND PER ADMISSION

IMPACT OF THE PRESIDENT'S PROPOSED MEDICARE PART A HOSPITAL SPENDING REDUCTIONS					
	1996	1997	1998	1999	2000
President's proposed Medicare Part A hospital reductions (in billions of $$) [1]	$ 5.7	$ 8.4	$ 11.8	$ 14.4	$ 17.2
Medicare HI enrollees (in millions) [2]	37.0	37.5	38.0	38.5	39.0
Proposed Medicare Part A hospital reductions per Medicare HI enrollee	$153	$224	$310	$374	$441
Percent reduction in annual Medicare Part A benefits per enrollee [3]	4%	6%	7%	8%	9%
Medicare hospital admissions (in millions) [4]	13	13	13	13	14
Proposed Medicare Part A hospital reductions per Medicare hospital admission	$445	$649	$897	$1078	$1265
Percent reduction in Medicare Part A hospital payments per admission [5]	5%	7%	10%	11%	12%

1 Source: Clinton Administration, September 24, 1993.

2 Source: Congressional Budget Office August baseline estimates 1996 through 1998. American Hospital Association estimates 1999 through 2000.

3 Source: American Hospital Association estimates of Medicare benefit payments per enrollee extrapolated from Health Care Financing Administration data through 1995 in *1993 Green Book*, p. 138.

4 Source: American Hospital Association estimates extrapolated from National Hospital Panel survey data through 1992.

5 Source: American Hospital Association estimates of Medicare hospital payments per admission extrapolated from Medicare cost report data.

Attachment 3

Table 5-3. Hospital Payments by Source, by State Averages, 1991 (In Percent)

State	Payments as a Percentage of Costs: Private Insurers	Medicare	Medicaid	Uncompensated Care Losses as a Percentage of Total Costs
U.S. total	130%	88%	82%	4.8%
New York	107	95	89	3.5
Maryland	108	108	107	7.1
Rhode Island	108	99	91	3.3
New Jersey	111	98	119	8.9
Wyoming	111	86	94	3.1
Minnesota	114	92	84	1.9
Michigan	118	90	85	2.7
Massachusetts	120	94	89	5.8
Wisc' 'sin	123	94	77	2.8
Arizona	124	94	80	4.0
Utah	124	87	88	3.5
North Dakota	124	88	96	2.2
Washington	124	100	82	3.3
Pennsylvania	126	90	74	2.7
Iowa	126	88	92	1.5
Oregon	126	96	65	5.3
District of Columbia	126	89	80	6.6
Ohio	128	87	90	4.0
Vermont	129	90	86	4.3
Kansas	130	88	82	3.5
Colorado	133	89	78	4.6
New Mexico	134	93	86	7.2
South Dakota	134	88	86	2.8
California	134	88	67	3.9
Montana	135	91	87	3.7
Maine	135	82	87	5.2
Indiana	136	85	99	4.8
Idaho	136	91	77	4.2
Missouri	137	87	77	5.3
Illinois	137	86	56	3.4
Nebraska	138	83	73	2.3
New Hampshire	138	83	90	5.8
Kentucky	138	90	99	4.9
Oklahoma	139	87	92	6.0
Texas	140	87	76	7.4
Connecticut	141	83	65	4.8
Virginia	142	90	73	6.2
Alabama	142	94	76	7.5
Georgia	142	87	88	7.5
West Virginia	142	90	85	7.3
Tennessee	143	87	82	6.1
Louisiana	144	87	87	3.8
North Carolina	145	89	85	5.8
Florida	146	84	82	7.7
Nevada	152	86	60	9.0
South Carolina	152	84	103	7.1
Mississippi	155	94	108	9.9
Arkansas	158	94	63	9.3

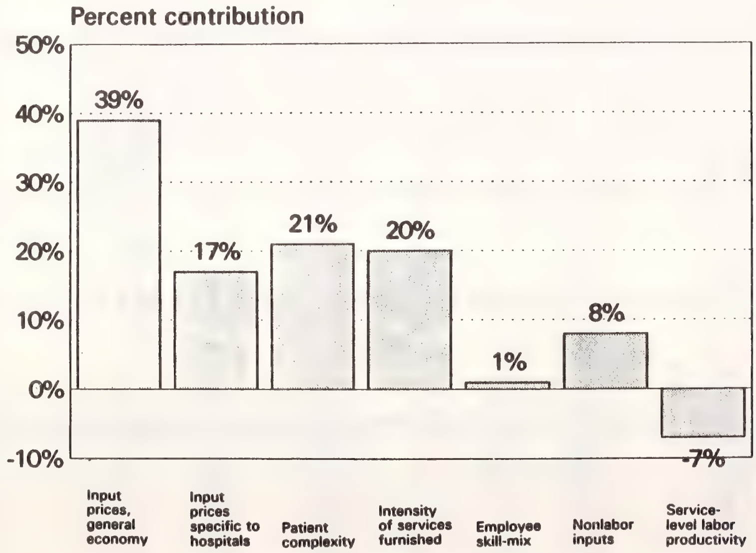
Note: In the first three columns, the payment received from each payer is shown as a percent of the cost of treating its patients. Uncompensated care losses (net of operating subsidies from state and local governments) are shown as a percent of costs across all payers. Alaska, Delaware, and Hawaii omitted due to insufficient data being available.

SOURCE: ProPAC analysis of Annual Survey data from the American Hospital Association.

Taken from: Prospective Payment Assessment Commission, *Medicare and the American Health Care System, Report to Congress*, June 1993

Attachment 4

Seven Factors Contributing to Hospital Cost Inflation 1985-1989



Source: ProPAC staff analysis
Health Affairs Vol. 11, No. 2, Summer 1992

Mr. WAXMAN. Mr. Halamandaris.

STATEMENT OF VAL J. HALAMANDARIS

Mr. HALAMANDARIS. Thank you, Mr. Chairman, it is a pleasure to be back. I too would like to join in commending you for the leadership you have shown through so many years in this area of protecting and preserving Medicare and providing health care as a right for all Americans.

We would also like to commend the President of the United States for his leadership. From our point of view, health care is a basic right of all Americans, the right of life, liberty, and the pursuit of happiness, freedom of press, freedom of religion, freedom of speech mean absolutely nothing without basic health care.

I suggest to you, as you well know, health care is the basic and the essential right. I believe that health care is the last great civil rights battle, so I commend the President for what he has done, the plan that he was put forward. I would also like to recall our history of John F. Kennedy failed twice in an effort to get Medicare enacted by the Congress, and then he made a speech in which he quoted the historian Arnold Toynbee and he said he had discovered that you could discover the greatness and durability of a society by a common yardstick. The yardstick was the manner in which the societies took care of their frail and elderly and disabled individuals.

The President said therefore, Medicare was not a question of whether we could afford it or whether we could afford not to do it, but whether we could afford not to take care of these populations, because what was at stake was our very future as a Nation and the way that we would be viewed through the prism of history.

Another thing that Toynbee found that was a common yardstick was the manner in which these societies kept their promises made to these people, a society which does not honor the promises government makes to the people should not be surprised that people do not honor their commitment to government.

As I wrote to the President of the United States, you cannot make a new covenant, you cannot forge a new covenant with the American people by breaching an existing covenant. The covenant that we have made with the American public and the elderly is Medicare and that needs to be honored and preserved and protected.

If it is abrogated, you cannot expect the elderly or indeed younger people to trust government in the future. So it is essential that Medicare remain intact. That takes me to a rather essential provision in the President's plan that gives us some trouble. In the main, we support the President's idea, but the notion that States could integrate Medicare into their existing plans is particularly troublesome for us.

It goes to answer the question Mr. Greenwood asked of the gentleman from AARP. If I were a Member of Congress, I would push an amendment which would bar absolutely States integrating Medicare into their existing plans until the entire plan had been fully implemented and been in place for 2 years.

As I understand it, the long-term care portions are supposed to come on line in the year 2003. Only when the plan is fully oper-

ational can the senior citizens of this country have some sort of informed choice as to whether it is in their interests to stay in the Medicare with the existing program or opt into the new plans that would be promulgated by the States under the Federal aegis. So I think that is a crucial point.

I would like to address now the cuts with respect to the Medicare program as it pertains to home care specifically. We all heard Mr. Vladeck say, when asked the question about home care and why we are proposing copayments and cuts, well, it is growing by 30 percent a year. We had to do something.

I want to address the question of why it is growing by 30 percent a year. Every budget reconciliation bill for the last 6 years, with the exception of one, included an amendment that the Congress added which broadened the scope of the Medicare home care provision. The Congress itself decided to do something about the institutional bias, broaden the scope of that program. So you are dealing with the Congress' intent to begin with.

The second thing, as he points out, the 30 percent growth in the Medicare program, you are starting with a very small base and therefore it looks bigger than it is. It also ignores the fact that about 27 percent more people are being served now than were served previously. What a concept. More people are getting served and therefore the cost of the program is being increased.

Other factors are DRG's and people being discharged from hospitals quicker and sicker into home care, the increase in technology. As you know, we do chemotherapy at home now whereas previously it was only available in the hospital, and that saves tremendous amounts of money to say nothing about what it does for people and their lives.

The demographics, more and more people are living longer and in need of health care services, being relatively more disabled, will put an increasing demand on the services that are being offered.

I would also point out that a lawsuit was promulgated by the National Association for Home Care with a group of senior citizen organizations, AARP, the Consumer Union, and 17 Members of Congress who were plaintiffs in this lawsuit, including several members on this committee.

That lawsuit was launched 3 years ago pointing out that the Health Care Financing Administration, HCFA, had illegally, arbitrarily, restricted Medicare home care benefit, and that lawsuit was concluded in favor of expanding the home care benefit under Medicare to the level at which Congress had intended, and that lawsuit is really what has brought about the significant increase in the Medicare program, and just to conclude, we made great use of charts here this morning, and I would like to present one for the record.

This chart demonstrates that home care has increased over the last 5 years by less than half of the cost of living. You see the numbers as they relate to hospital care, the numbers relating to physicians, and as we see a 46 percent increase in hospital costs, physician services, 32 percent, and home care has increased by 8.9 percent—8.1 percent or roughly half of the cost of living.

I take the President at his word. The President says under Medicare we are going to restrict it, reduce it from three times the rate

of inflation back to two, and I would just suggest that any time you have a program that is running at half of the rate of inflation, it should be exempt from further cuts.

Mr. WAXMAN. Thank you very much, Mr. Halamandaris.

[The prepared statement of Mr. Halamandaris follows:]

Testimony of Val J. Halamandaris, President

National Association for Home Care

My name is Val Halamandaris. I am President of the National Association for Home Care (NAHC), which represents the nation's home care providers -- including home health agencies, home care aide organizations, and hospices -- and the individuals they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all individuals who require them. Toward this end, NAHC has long advocated the development of a national plan to ensure universal access to basic acute care and long-term care services.

I am pleased to be here today to discuss President Clinton's health care reform proposal and its potential effect on the Medicare program. Before I begin, though, I want to commend Chairman Waxman for the leadership he has demonstrated during the Committee's ambitious schedule of hearings on health care reform, and also to acknowledge the tremendous efforts he and the other members of the Committee have taken to protect the interests of Medicare beneficiaries and the Medicare program.

NAHC supports key elements of the Clinton health care reform proposal which are consistent with the top three priorities as established by the NAHC membership last year: (1) The plan preserves the Medicare program; (2) Home care and hospice are a part of the acute care benefits package; and, (3) The plan includes a new comprehensive long-term care benefit based on home care. With respect to the Medicare program, we are not only pleased that the plan will keep Medicare intact, but we are also supportive of the proposed Medicare prescription drug benefit, which will include coverage of home infusion drug therapy. However, based on our review of the legislative language that President Clinton presented to Congress earlier this month, we have several concerns about the impact of the plan and some of its proposed financing mechanisms on the Medicare program.

Home Health Care Cost Limits

Although we understand that the Medicare reductions under this proposal would be used to fund health care reform rather than used for deficit reduction proposals, NAHC is still extremely concerned about the proposed reductions in the home health benefit. Specifically, NAHC is opposed to the proposed reduction in the home health cost limits from 112% of the mean to 100% of the median. This reduction would come on top of significant administrative cuts in the Medicare cost limits, which the Health Care Financing Administration promulgated earlier this year, and a two-year freeze included in the fiscal year 1994 budget reconciliation act. It is estimated that over half of the Medicare-certified home health agencies will be adversely affected by the current cost limits by 1995. Switching to 100% of the median would bring an estimated, additional 15% reduction in the cost limits. Reducing the cost limits requires agencies to further reduce their costs in the very area where they have already exercised considerable restraint. From 1987 to 1991, for example, the cost-of-living index (CPI) increased by 19.8%; physicians and medical services increased by 32.2%; and hospital costs soared by 46.3%; however, Medicare home

health visit costs increased by only 8.1% during the same period -- well under half the increase in the cost of living index.

The impact of the newly proposed costs limits, coupled with the previously mentioned administrative cuts and two-year freeze, will have a disproportionate, adverse effect on certain states. One of the most striking and unexpected findings from a September 1993 study conducted by NAHC is that the size of the cost limits' impact on a state tends to vary inversely with the use of home care services in the state. In other words, the states that use the fewest services are also the hardest hit by the cost limits, and it gets worse if you lower them. By 1995, Medicare beneficiaries in the one-third of the states hardest hit by the new cost limits will receive only a little more than half as many visits as beneficiaries in the states that are least affected. Cost limit reductions, like those envisioned in the Clinton plan, will clearly then only inhibit the ability of agencies to deliver, and beneficiaries to receive, vital, cost-effective home health care services.

Home Health Care Copayments

Another area of concern to NAHC centers on the Clinton Administration's intention to impose a 10% copayment on Medicare home health services. For several reasons, we oppose such a regressive and inefficient proposal.

First and foremost, a 10% copayment for home health services will affect the poorest and oldest Medicare beneficiaries. For many beneficiaries, the $8.3 billion in savings the proposal projects for the Medicare program will translate into copayments of several hundred dollars a year. Home health care recipients are older and have even fewer financial resources than the general Medicare population. Individuals over age 75 account for less than half of the total Medicare population, but comprise nearly three-fourths of the home health beneficiaries. A copayment for home health services, therefore, would fall most heavily on the oldest group of Medicare beneficiaries. In fact, while individuals over age 85 bear 12% of the total revenues raised by the Part B copayment, they would be responsible for 25% of the revenues raised by the home health copayment.

The elderly are already health-care poor without this new expense. Seniors spend nearly twice as much of their income on health care as they did before Medicare began (10.6% in 1961 compared to 17.1% in 1991). And 12.2% of the elderly now live below the federal poverty level. In addition, nearly three-fourths of the poor elderly do not own Medigap insurance to help cover the costs of copayments. Even the Medicaid and Qualified Medicare Beneficiary (QMB) programs provide inadequate protection from these costs. In 1990, less than a third of the elderly poor received Medicaid assistance and fewer than half of those eligible for the QMB program -- a program designed to help poor seniors avoid the substantial out-of-pocket costs related to Medicare -- received the benefit.

We also oppose home health care copayments because copayments are notoriously inefficient. In particular, the collection of copayment

amounts would create unnecessary paperwork. Many home health patients receive only a few visits (29% received fewer than 10 visits in 1991). However, agencies would have to set up billing and tracking programs for even these relatively small amounts.

Finally, we believe that a copayment requirement for home health would exacerbate the institutional bias inherent in the Medicare program by creating strong disincentives to use home health services. Home health was exempted from the Part B coinsurance in 1972 in order to encourage utilization of less costly non-institutional services. Reimposing a coinsurance would dramatically undermine that effort and create strong financial incentives for institutional care. Thus, for all of these reasons, we ask that the Administration and Congress work together to determine a more equitable and efficient mechanism for financing needed Medicare and long-term home care benefit expansions.

Preservation of Medicare

As I stated earlier, NAHC strongly endorses the Administration's decision to keep the Medicare program intact. Medicare has proven to be an overall effective program that through the years has been tailored to meet the special needs of our nation's most medically and economically vulnerable citizens. More importantly, the program represents a covenant with the American people that should not be broken by the Federal government. However, there are purely practical reasons for preserving Medicare as well.

First, Medicare has already resolved some of the major problems that we are seeking to remedy through health care reform. Medicare beneficiaries, for example, have access to affordable care, and the costs of financing care for Medicare patients is equitably distributed. This is in stark contrast to the current system where the uninsured receive inadequate care at the expense of the insured.

Medicare is also a popular program. As evidence, in areas of the country where beneficiaries were given the choice of either staying in Medicare or enrolling in another alternative delivery system, only 5% chose to enroll in a health maintenance organization. (Health Care Financing Administration, 1993.) Clearly, the current Medicare coordinated care strategies that are available to Medicare beneficiaries have not attracted many beneficiaries.

Another reason the Medicare program should be kept intact is because it is a tried and tested program. For all of the effort and thought that has gone into drafting the Clinton health care reform proposal, it is still a risky venture. Implementation of a new health care reform proposal that will substantially alter one-seventh of the American economy is bound to at least temporarily disrupt the continuity of care for certain populations. At least by allowing the 34 million Medicare beneficiaries to remain in the Medicare program, the Administration's difficult task of implementation will be lessened. Further, Medicare beneficiaries, some of our nation's most fragile citizens, will be spared the pains of what could be an arduous transition.

Of course, NAHC is concerned about a provision of the President's plan that would allow the states to enroll Medicare beneficiaries into an alternative plan, so long as the states could prove that the benefits would be equal or superior to those offered under Medicare. My experience with Medicaid, the deinstitutionalization of the mentally ill, and other state initiatives leads me to conclude that while such a diversion to a state plan might appear to be initially attractive, any proposal that could force the elderly to surrender their federal Medicare entitlement could ultimately prove to be a poor exchange.

While we strongly endorse the Administration's decision to keep the Medicare program intact, we clearly have some concerns regarding certain provisions of the Clinton Health Security Act and the impact that these provisions could have on the status of the Medicare program. We know that Members of Congress share many of our concerns and we look forward to working with the Congress, as well as the Administration, to ensure that Medicare beneficiaries will also reap the benefits of health care reform.

Mr. WAXMAN. Ms. Foster.

STATEMENT OF HOPE FOSTER

Ms. FOSTER. Mr. Chairman, my name is Hope Foster and I am General Counsel of the American Clinical Laboratory Association, an organization of federally regulated independent clinical laboratories.

ACLA and I join my fellow witnesses here today in commending you, the other members of this subcommittee, and the President in addressing these very important issues, and appreciates the opportunity to comment on the Medicare cuts that are proposed in the President's Health Security Act.

In addition, I will briefly discuss the laboratory reform plan that ACLA developed last spring.

The President's Health Security Act includes two Medicare provisions that would directly affect laboratories. The reimposition of co-insurance on beneficiaries and the use of competitive bidding to purchase laboratory testing services.

These provisions represent poor health care policy because they would result in significant reductions in Medicare payment for laboratory services, which would adversely affect both laboratories and the beneficiaries who need testing services.

According to administration estimates, the two provisions would lower Medicare spending over 5 years by about $9.18 billion, an amount that is 2½ times what Medicare part B spent on all laboratory services in 1992.

These cuts would be imposed on top of the $3.3 billion in reductions that were mandated by OBRA 1993. Taken together, the cuts included in OBRA and those proposed in the President's Health Security Act would constitute a decrease of approximately 40 percent in Medicare payments to laboratories.

A reduction seems especially excessive in view of the fact that laboratories only represent about 5 percent of Medicare expenditures.

As I noted when I came, the plan would reimpose on Medicare beneficiaries a 20 percent co-insurance requirement for laboratory testing. Congress eliminated this in 1984 when the current fee schedule methodology was adopted which set fees at 60 percent of the then prevailing levels.

This subcommittee was active in that action. The problem with co-insurance is that because of collection and billing costs, the requirement would in effect be an additional cut in Medicare laboratory reimbursement.

ACLA members conservatively estimate that this de facto reduction would be about 15 percent. Although the cost of co-insurance is just a few dollars, it would usually cost more than this amount to generate the additional invoice required to bill it.

Experience also shows that laboratories typically must write off a large percentage of billed co-insurance because of uncollectability.

Finally, because patients do not order testing or choose the laboratory to perform the service, co-insurance is unlikely to affect utilization of these services, a fact recognized by the CBO in a 1990 report. The administration's plan would also permit the adoption of

a winner take all competitive bidding procedure for laboratory services.

If the procedure did not result in an additional 10 percent outlay reduction, the Secretary would have authority to order further cuts to achieve such a reduction. In the past, when government entities have tried such arrangements, quality was seriously compromised because some providers submitted low-ball bids and then could not afford to provide services at the winning price. As a result, patients' health was placed at risk.

In a 1984 report, HCFA itself expressed concerns about such proposals and Congress has repeatedly blocked implementation of such a plan through statutory moratorium. Furthermore, the plan proposed by the administration could result in reduced access for patients because losing bidders might well have difficulty remaining in operation, and some smaller laboratories might not be able to participate at all if they did not serve the broad geographic area required by the plan.

Finally, the plan's requirement for a minimum 10 percent reduction in expenditures fails to consider whether such cuts are reasonable or justified. In a letter to Members of Congress that is attached to our written statement, 11 groups representing a cross section of those involved in the delivery of laboratory services agree that these proposals threaten the ability of laboratories to continue to provide high-quality services to all who need them.

ACLA does recognize, however, the need for reform of the health care system, including the system in which laboratories are operated. That is why earlier this year we adopted our own proposal. The centerpiece of that plan is the enactment of a Federal law mandating direct billing of laboratory services.

A recent study conducted by the Center for Health Policy Studies, a copy of which I have here and I believe has been delivered to the subcommittee earlier, estimates that enactment of such a law would save between $2.4 and $3.2 billion a year for a 5 year savings of between $12 billion and $16 billion.

Our plan also calls for the establishment of payment caps on laboratory reimbursement from private payers similar to Medicare's payment caps. Because of the shortage of time, I cannot discuss the other elements of our plan, but we would be happy to answer your questions, and we look forward to working with you and other members of the subcommittee.

Thank you.

Mr. WAXMAN. Thank you very much. The rest of the points you wanted to make will be in the record.

[Testimony resumes on p. 483.]

[The prepared statement of Ms. Foster follows:]

AMERICAN CLINICAL LABORATORY ASSOCIATION
1919 Pennsylvania Ave., Suite 800, Washington, D.C. 20006/(202) 887-1400

**STATEMENT OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION
REGARDING MEDICARE CUTS
INCLUDED IN HEALTH CARE REFORM**

November 15, 1993

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on the Medicare cuts that are included in the President's Health Security Act, and their impact on the laboratory industry. ACLA is a trade association of federally regulated, independent clinical laboratories and represents national, regional and local laboratories located throughout the United States. All ACLA members will be significantly affected by these proposals.

Laboratory testing is an important, cost-effective and life-saving health care tool, which permits the early detection and treatment of a variety of diseases and conditions. Just a few examples illustrate its importance. Testing for cholesterol and related measurements for HDL and LDL help reduce the risk of heart disease. Pap smear screening has led to significant reductions in deaths from cervical cancer. A simple screening test given to newborn babies detects PKU, a metabolic disorder that is treatable if caught early, but which can lead to retardation if left undiscovered. Other tests are routinely used to monitor the effectiveness of medication given to treat cancer and other serious diseases. In short, the early diagnosis and effective treatment permitted by appropriate testing ultimately enhances health, saves lives and reduces costs.

In our statement today, we will first address the laboratory reimbursement reductions included in the President's plan. Then we will discuss the health care reform plan that ACLA proposed in March 1993. ACLA believes that its plan represents a thoughtful and reasonable course for reforming clinical laboratory reimbursement.

A. The Administration's New Cuts Will Have an Adverse Effect on the Provision of Laboratory Services

ACLA welcomes this opportunity to appear today to discuss the Medicare cuts that are included in the President's Health Security Act, and that would be used to finance a portion of the cost of health care reform. ACLA has always recognized its responsibility to accept reductions in reimbursement when necessary. In the past, we have frequently worked with this Committee in crafting appropriate and equitable decreases in laboratory reimbursement to help bring about necessary deficit reduction. The proposals included in OBRA'93, which will reduce laboratory reimbursement by more than $3.3 billion over the next five years, were developed with significant input from ACLA.

Today, we are here to discuss still further cuts in Medicare reimbursement for laboratories. The President's plan would reimpose laboratory coinsurance obligations on Medicare beneficiaries, a provision that Congress eliminated in 1984 with the support of HCFA and the laboratory industry, when the current fee schedule methodology was adopted. In addition, the President's plan would also authorize the use of competitive bidding to purchase laboratory services for Medicare. While ACLA is committed to the need for meaningful health care reform, we believe these proposals represent faulty health care policy that would ultimately have a significant, deleterious effect on the laboratory industry.

According to Administration estimates, these provisions would reduce Medicare payments to laboratories by approximately $9.8 billion. This cut is more than two and a half times what Medicare Part B spent on laboratory services in all of 1992. Furthermore, the proposed reductions, in combination with those already mandated by OBRA'93, which Congress just passed last August, would constitute a total decrease of approximately 40 percent in Medicare payments to laboratories. These reductions seem especially unfair in view of the fact that laboratories only represent about 5 percent of total Medicare expenditures. As stated in a recent letter to all Members of Congress, which was signed by 11 groups representing a cross section of those involved in the laboratory industry, these cuts "will threaten the ability of laboratories to provide high quality services; to employ the most qualified individuals; and to ensure that all Medicare beneficiaries enjoy access to necessary laboratory services." A copy of that letter is attached.

ACLA does not object to appropriate changes in the manner in which clinical laboratories must operate. As discussed below, the health reform plan adopted by ACLA would lower utilization of laboratory services and reduce the amount that all payors spend on such services by

between $12 billion and $15 billion over five years. However, the Administration's proposals will ultimately injure both laboratories and beneficiaries alike.

1. Competitive bidding will harm access and quality

Section 4119 of the Administration's plan would establish a competitive bidding procedure for the acquisition of laboratory services. Although the actual procedures are unclear in the bill, it appears to create a "winner take all" approach, which would give the laboratory awarded the contract the exclusive right to provide laboratory services within a given geographic area. In addition, the plan states that if the competitive bidding plan procedure did not result in a 10 percent savings, the Secretary would have the authority to order further cuts to achieve a reduction of this amount.

ACLA has numerous concerns about this competitive bidding proposal. First, previous federal use of competitive bidding for laboratory services has been unsuccessful. When the Air Force awarded a contract to a laboratory for screening Pap smears on the basis of competitive bidding, the laboratory, which won the contract based on submitting the lowest bid, performed so negligently that women's lives were placed at risk. The Air Force was forced to impound over 700,000 Pap smears that they found contained numerous errors. Other experiments with competitive bidding have encountered similar difficulties.

In the mid-1980s, HCFA contracted with Abt Associates of Cambridge, Massachusetts to design, implement and evaluate a competitive bidding demonstration project for laboratory testing. However, that proposal, which many laboratories believed had significant structural problems that made it unworkable, was never implemented or tested nor was it ever the subject of full-blown public comment. Indeed, for several years, Congress passed a moratorium as part of the HHS appropriations bill which prevented the agency from spending any government funds to implement the Abt proposal.

The "winner take all" arrangement included in the Administration's plan is especially problematic. Under these types of plans, there would be a strong incentive for a bidder to submit a "low ball" bid, in order to obtain the contract, a fact that could have disastrous implications for the quality of the testing. In fact, in 1984, a HCFA report on the laboratory industry expressed great skepticism over competitive bidding. It noted that under a competitive bidding system:

> [l]aboratories might knowingly underprice the competition in order to win a Medicare contract, even if they know they will be unable to cover their costs at the bid price. This practice, known as "low-balling," has occurred in even limited competitive contracts for

services awarded by the Air Force and by the District of Columbia.[1/]

Further, the Administration's plan could actually lead to reduced access for many Medicare beneficiaries. Because Medicare amounts to a large percentage of many laboratories' revenues, a laboratory might find it difficult to survive if it were unable to continue to provide services because it was a "losing" bidder. Similarly, it is unclear whether physician office and hospital laboratories would be able to participate under the Administration's plan. Because they often do not serve as broad an area as independent laboratories, they might find it difficult to compete under the plan.

In addition, physicians often have strong preferences about which laboratory they wish to serve their patients. Laboratories have different levels of quality and service; therefore, a physician may prefer one laboratory over another. A competitive bidding arrangement would reduce the ability of the physician to choose the laboratory that he wants to serve his patients.

Finally, the Administration's proposal would require a minimum 10 percent reduction in expenditures, if such savings were not achieved by competitive bidding. This is a wholly arbitrary standard that does not consider whether the reductions are reasonable or justified. In short, the competitive bidding mechanism envisioned by the Administration's plan would threaten the ability of laboratories to provide high quality services and the access to such services enjoyed by beneficiaries.

2. Coinsurance represents an additional cut in reimbursement

ACLA must also object to the reimposition of coinsurance for laboratory testing provided to Medicare beneficiaries. This requirement was eliminated by Congress in 1984, with the approval of the laboratory industry and HCFA, when the current fee schedule methodology was adopted. The reimposition of this requirement would add to the health care costs already borne by Medicare beneficiaries and have an injurious effect on laboratories.

Imposition of coinsurance would, in actuality, constitute a cut in laboratory reimbursement because in many instances, the cost of billing the coinsurance would exceed the amount collected. Although the amount of the coinsurance is usually just a few dollars, on average, it would cost between $3.00 and $5.00 just to produce the additional invoice covering the coinsurance, a cost that could easily exceed the amount collected.

1/ HCFA, *Report of Laboratory Task Force* at 23 (1984).

Further, in most instances, the cost of collection would be even higher than $3.00 to $5.00. If the patient did not pay after receiving the first statement and follow-up were necessary, the costs to the laboratory would obviously increase. Furthermore, past experience with coinsurance suggests that in many instances, laboratories would have to write off from 20 to 50 percent of the billed amounts because of uncollectablity. Indeed, these problems are the very reason that Congress eliminated the coinsurance requirement in 1984 and mandated the current methodology, which set fee schedules at 60 percent of then-prevailing charges.

Furthermore, reinstatement of coinsurance would have a negative impact on beneficiaries because it would force them to incur higher outlays and could reduce their access to laboratory services. As noted above, reimposition of coinsurance amounts to a substantial cut in reimbursement for laboratories, a cut of at least 15 percent, according to ACLA members. This reduction, coupled with the cuts imposed by OBRA'93 and previous budget laws, could adversely affect both the quality of the services that laboratories are able to provide and the access to services that beneficiaries currently enjoy.

Finally, coinsurance for laboratory services would have no effect on utilization of laboratory services. For ancillary services, such as laboratory testing, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization because patients do not decide when to order testing nor do they select the testing laboratory. Medicare covered laboratory services can only be ordered by physicians. As the Congressional Budget Office noted in a 1990 Report:

> Cost-sharing probably would not affect enrollees' use of laboratory services substantially, ...because decisions about what tests are appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.[2/]

In sum, while ACLA supports the need for health care reform, we believe both competitive bidding and coinsurance will have a significant, adverse effect on the laboratory industry and the ability of beneficiaries to obtain quality laboratory services.

B. ACLA's Health Reform Plan

ACLA does recognize, however, that health care reform, including reform of the laboratory industry, is urgently needed. ACLA has frequently come before this Subcommittee and urged the enactment of legislation that would bring about significant structural reform of the manner in

2/ CBO, "Reducing the Deficit: Spending and Revenue Options" at 140 (February, 1990).

which laboratory testing is delivered. Earlier this year, in March 1993, ACLA adopted its own health reform plan, which it presented to this Subcommittee during consideration of OBRA'93.

In crafting our reform plan for laboratories, ACLA was guided by three overriding principles. First, such a plan should promote a more cost-conscious and efficient health care system. Second, it should ensure that all patients have access to high quality laboratory testing. Third, it should simplify the rules and procedures that govern the system.

The plan that ACLA drafted in March promotes all three goals. First, it would promote a more efficient system by eliminating those features that lead to overutilization of, and excessive prices for, laboratory testing. It would also end wasteful cost-shifting and impose meaningful cost-containment controls.

Second, ACLA's plan would ensure access to high quality laboratory testing for all those who need it. ACLA continues its long-held support for the goals of CLIA'88, and opposes any wholesale rollback of the law's safeguards. Further, as noted above, we must oppose the Administration's competitive bidding and coinsurance proposals because they will have a significant, and deleterious, impact on the quality of laboratory testing.

Third, the ACLA plan would simplify the system by establishing a process to clarify the rules covering certain types of laboratory tests. And, it would require that the current Medicare system, which unnecessarily relies on over 33 different carriers, all with their own rules and procedures, be streamlined and centralized.

ACLA's plan is a comprehensive program and will only achieve its goals if all of its components are adopted. In our testimony today, we would like to explain why reform of the industry is so urgently needed and how our proposal will help achieve the goals set out above.

1. Promote a Cost-Conscious and Efficient System.

In encouraging cost-consciousness and efficiency in the laboratory industry, ACLA would rely on the rules that Congress has already developed to reduce laboratory utilization and costs in the Medicare program. Several of these provisions, including a direct billing mandate and a system of payment caps, have worked well for Medicare and should be extended to other payors. In our view, a primary reason that the system is in need of reform is that these safeguards have only been applied to Medicare rather than to all payors.

a. Extension of direct billing mandate to all payors

The centerpiece of the ACLA plan is the enactment of a federal law mandating direct billing of laboratory services; i.e., a requirement that the laboratory that performs the testing bill the patient or insurer for those services. This provision would simplify the structure of the industry and lead to a more rational, and efficient, market for laboratory services. Direct billing is required by H.R. 200, which Congressman Pete Stark introduced earlier this year, and by S.337, which Senators Jeff Bingaman and Howard Metzenbaum sponsored.

Enactment of such a requirement would promote a more cost-conscious and efficient system for delivery of testing services than currently exists. Today, laboratories are not required to bill the patient or responsible third-party payor for testing. As a result, physicians often request that they be billed for the testing that they order for their non-Medicare patients. The physician can then mark up this testing, often by a significant amount, when he bills the patient or the appropriate third-party payor. This system can lead to increased testing because it gives the physician the ability to profit from his own test ordering, just as in the case of self-referral.

Because of the concerns raised by this practice, the federal government has prohibited it in the case of Medicare. The Medicare law requires the laboratory that performs the testing to bill the Program directly in most cases. The laboratory is barred from billing the physician that ordered the services. Thus, enactment of direct billing would simply extend the benefits of the Medicare rule to private payors and patients.

Enactment of direct billing would have several important benefits. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies ("CHPS"). CHPS compared the experience of Medicare and Blue Cross/Blue Shield plans in direct billing and non-direct billing states. The CHPS report, which we have previously supplied to Members of the Subcommittee, found that laboratory prices and utilization were dramatically higher in non-direct billing states than in states that require direct billing. Among the study's findings were the following:

- Charges for laboratory services were 8.4 to 9.6% higher in non-direct billing states than in direct billing states.

- Laboratory utilization per enrollee was higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization was 6.5% higher and for tests reimbursed by private payors--where incentives for overutilization are greatest--it was 28.3% higher.

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- Laboratory charges per enrollee under private health insurance programs, a measurement that takes into account both utilization and price differences, were 40.6% higher in non-direct billing states.

The report concludes that if a national direct billing law were enacted, annual savings in health care expenditures of between $2.4 and $3.2 billion could be achieved, as a result of reduced utilization and lower prices. This translates into savings of between $12 and $16 billion over the next five years.

It is particularly appropriate that we should come before this Subcommittee today to discuss direct billing. This Subcommittee has supported the elimination of incentives that increase the use of laboratory testing. It helped enact limits on the practice of self-referral in the clinical laboratory industry because of the practice's effect on utilization. Chairman Waxman has sponsored legislation that would make these limits applicable to services reimbursed by private payors, as well as Medicare and Medicaid, an effort that ACLA supports. The enactment of direct billing would complete that effort by eliminating another practice that provides an incentive for increased use of laboratory testing.

b. Reduce Cost-Shifting Through Enactment of Appropriate Cost Containment Measures Applicable to All

Along with the extension of direct billing to all payors, ACLA's plan also calls for the establishment of payment caps on laboratory reimbursement from private payors, similar to the methodology that currently exists under Medicare. ACLA's proposal calls for these caps to be set at the actual median of the Medicare fee schedules, as defined in Section 1833(h) of the Social Security Act.

Enactment of such a provision would substantially lower reimbursement in the private sector. In addition, the combination of direct billing and fee caps would further ensure that the benefits of price and service competition are enjoyed by the ultimate payor, either the patient or insurer. While it is impossible to calculate precisely how much such a provision would save, as competition could ultimately drive prices below this cap, ACLA expects the savings would be substantial.

The adoption of both of these measures together is a necessary predicate to the creation of a cost-conscious and efficient system.

2. Protect the Quality of Clinical Laboratory Testing

The second goal promoted by ACLA's health care reform plan is to protect and enhance the quality of laboratory testing. Congress has already taken the most important step towards ensuring quality, by enacting the Clinical Laboratory Improvement Amendments of 1988. This law required for the first time that all laboratories, regardless of site, would be subject to federal jurisdiction and assured that they would comply with appropriate, minimal quality assurance rules. Prior to the enactment of CLIA, the vast majority of laboratories were unregulated by federal or state law. Hearings held at the time demonstrated that unregulated laboratories often failed to hire the most qualified personnel, follow quality control procedures, or participate in proficiency testing. CLIA was passed to correct these problems. As a result, ACLA supports the implementation of CLIA and must oppose any substantial weakening of its standards.

3. Promote Simplification

The third goal of the ACLA plan is to promote simplification of the current system. The ACLA plan has two points to promote this goal in the laboratory industry: clarification of rules relating to profiles and administrative simplification.

a. Clarify the rules relating to test profiles

"Test profiles" are groups of related tests that are often ordered together. For example, a physician ordering tests for a patient with liver disease may order a "hepatic profile," a group of tests used for patients known or suspected to have this condition. While profiles are a necessary and valuable tool, the rules governing their ordering and billing have long been unclear.

Because of confusion in this area, ACLA has adopted guidelines, which we would be happy to share with the Members, to help ensure that physicians ordering profiles understand what they are ordering and what the financial consequences of their test-ordering decisions are likely to be. Even more needs to be done in this area, however. Currently, there is no uniform set of rules concerning what may be included in a particular profile, a circumstance that adds to the confusion. Therefore, ACLA's plan calls for the establishment of a process to govern the development and modification of standardized profiles with established test components. ACLA would be pleased to work with the Department of Health and Human Services and various medical societies in developing such a list.

b. Promote administrative simplification

Today, at least 33 different Medicare carriers have jurisdiction over laboratories providing testing to Medicare beneficiaries. Because laboratories often have testing facilities in more than

one state, several different carriers, each with its own procedures and policies, usually have jurisdiction over a laboratory's operation. This system leads to confusion and unnecessary effort for all parties. As a result, the current system should be changed, so that laboratories could submit Medicare claims to a single carrier.

Further, the system should be clarified so that all providers understand what medical and insurance information must be obtained from each patient. This change would be especially important for laboratories, because they often do not have direct contact with the patient and have difficulty obtaining the required information if it is not provided initially by the physician.

Conclusion

ACLA is pleased to have this opportunity to testify before the Subcommittee today. We look forward to working with you in achieving the three goals of promoting a more efficient and cost-conscious system, protecting the quality of laboratory testing, and simplifying the system. We would be happy to answer any questions.

November 12, 1993

The Honorable Henry A. Waxman
U.S. House of Representatives
Chairman, Subcommittee on Health and the Environment
Committee on Energy and Commerce
2408 Rayburn House Office Building
Washington, DC 20515

Dear Representative Waxman:

The undersigned groups represent a broad cross section of those involved in the provision of laboratory testing services. While we share a commitment to health care reform, we are writing to express our strong opposition to health care reform and budget proposals that target clinical laboratories for disproportionate and unfair reductions in Medicare reimbursement. The President's Health Security Act would reimpose laboratory coinsurance obligations on Medicare beneficiaries and would permit competitive bidding procurement of laboratory services for Medicare. Other bills, including the deficit reduction packages introduced by Congressmen Kasich and Penny and by Senators Kerrey and Brown, also mandate the reinstatement of laboratory coinsurance on beneficiaries.

As discussed below, these proposals would result in a significant cut in Medicare laboratory reimbursement. When added to reductions already mandated by OBRA '93, these provisions would constitute a total decrease of approximately 40 percent in Medicare payment to laboratories, even though laboratory payments only represent about 5 percent of total Medicare expenditures. Cuts of this magnitude will threaten the ability of laboratories to provide high quality services; to employ the most qualified individuals; and to ensure that all Medicare beneficiaries enjoy access to necessary laboratory services. As discussed below, each of these proposals would threaten the goals of health care reform.

Coinsurance

Because the amount of laboratory coinsurance on each claim is actually quite small -- often just a few dollars -- the cost of billing the copayment actually exceeds what is collected. Laboratory coinsurance is also difficult to collect, resulting in large bad-debt write-offs. As a result, some laboratories estimate that reenactment of coinsurance would constitute a cut in reimbursement to laboratories of at least 15 percent. Because of these concerns, when Congress adopted the current Medicare fee schedule methodology in 1984, it eliminated the coinsurance requirement with the approval of HCFA and the laboratory industry. Under this system, laboratories are required to accept assignment and cannot bill Medicare beneficiaries for covered services. This policy is reasonable because, unlike other forms of coinsurance, laboratory coinsurance does not affect utilization, a fact recognized by CBO in a 1990 report, because physicians, not patients, decide whether to order laboratory tests.

Competitive Bidding

Similarly, competitive bidding is also likely to have an adverse impact on laboratory services. In the past, Congress blocked implementation of a competitive bidding proposal offered by HCFA, because of concerns about its workability. The President's plan would create a "winner take all" competitive bidding plan for laboratory services that would have to lower expenditures by 10 percent per year, or other reductions in reimbursement would be triggered. Under this plan, only the winning laboratory would be able to supply Medicare services. Services supplied by other laboratories in the area would presumably be denied.

In the past when such laboratory competitive bidding systems were used by government and military programs, some providers submitted "low ball" bids to obtain the contract; however, they then could not afford to provide the services at the bid-winning price, quality was seriously compromised, and patients' health was put at risk. Moreover, requiring a minimum 10 percent reduction in expenditures is a wholly arbitrary standard that does not consider whether the reductions are reasonable or justified. Finally, such a competitive bidding system fails to recognize that laboratory services are a specialized, health care service; not a commodity. Physicians, therefore, often have strong preferences among laboratories because of quality and service differences. A competitive bidding plan such as that envisioned by the President's plan would remove the ability of physicians to choose the laboratory they believe best serves the needs of their patients.

Direct Billing

Laboratory providers do wish, however, to contribute positively to the health reform process. That is why members of the undersigned groups have supported measures to control laboratory costs and utilization, such as direct billing of laboratory services. Direct billing of all laboratory services, which would be mandated by S.337 introduced by Senators Jeff Bingaman and Howard Metzenbaum and by other health reform plans, would require that the laboratory that performs the testing also bill the patient or insurer for those services, rather than the physician who ordered the testing, as often happens today. Because the physician frequently marks up the price charged for the testing, the current system leads to increased utilization and higher laboratory costs. As a result, the federal government prohibits this mark up in the case of Medicare, but the practice continues with other payors. An independent study has shown that if the Medicare direct billing requirement were extended to all payors, it would reduce utilization of laboratory testing and lower costs, resulting in annual savings to the health care system of between $2.4 and $3.2 billion -- or between $12 and $16 billion over five years.

We strongly urge you to oppose the competitive bidding and coinsurance proposals currently being offered and hope you will support the enactment of a direct billing requirement.

Sincerely yours,

American Association for Clinical Chemistry
American Association of Bioanalysts
American Clinical Laboratory Association
American Medical Technologists
American Society for Clinical Laboratory Science
American Society of Clinical Pathologists
Clinical Laboratory Management Association
College of American Pathologists
International Society for Clinical Laboratory Technology
Nichols Institute
National Association for the Support of Long Term Care

Mr. WAXMAN. We might get into it in questions anyway as well.

Mr. Pollack let will he me start with you, I understand that the AHA is strongly opposed to the Penny-Kasich amendment. I wonder if you could tell us what the proposal to income test the hospital deductible would be on hospitals, and would hospitals have to ask their patients to bring their tax returns in with them.

Mr. POLLACK. I appreciate the question, we are most definitely opposed to Penny-Kasich. It represents a continued chipping away at the Medicare policy outside of the context of reform.

With regard to the specific issue you have raised, there are a whole list of operational questions with regard to the administration of those deductible changes that would be nothing short of a nightmare, and if it was enacted, I would predict that we would be back here looking at technical corrections to fix it up after we are through.

A whole series of problems concerning its administration, it puts hospitals in the position of having to figure out what people's income limits might be, and we have a whole range of concerns as to how you would administer it.

We would be pleased to provide further information for the record, but you have put your finger on a piece of this that is of grave concern to us.

Mr. WAXMAN. Thank you. We would like to get any other thoughts you have for the record so we can get that information out in the very, very short time that some members are being asked to even think through this, I think, very dangerous proposal.

You testified that the Medicare program should be more fully integrated with the system proposed for private health plans. You argue that it would be almost impossible to operate a hospital with Medicare patients covered largely by a fee-for-service plan while most other patients were in managed care plans.

Mr. Halamandaris, you take quite a different tack in your statement. You make a strong case for keeping Medicare largely as it is based on its success in providing coverage to elderly and disabled people.

I am interested in how representatives of hospitals and home care agencies see this issue so differently. Would either of you like to comment on why you think your organizations have reached such different conclusions?

Mr. HALAMANDARIS. Well, Mr. Chairman, if I can go first, we are all a victim of our backgrounds and mine was chief counsel for a congressional committee for 20 years and investigating fraud and abuse in Medicare and Medicaid programs. I did most of those investigations and I can tell you that the programs that are most vulnerable are the grant and aid programs and contract programs. The Medicare program, for all its faults, runs reasonably well from the point of view of fiscal integrity.

So Medicare is a known entity. It goes back to what I said about making a covenant with the American people. We should be consistent with that. We are not sure what the shape of any new plan is going to be, and until we know what the new plan is going to be and how it works, we are reluctant to advise the senior citizens to abandon what they have in favor of something else, particularly if it may be vulnerable to abuse or fraud.

Mr. POLLACK. We have come to the conclusion that the way to deliver health care services in the most effective and efficient way is not through a fee for service approach where it is essentially pieces in its fragmentation and nothing is connected, and you have people going to a variety of different providers and you never know if anybody is ever talking to one another.

We see the movement towards seamless systems of care that coordinates people's care. So from that perspective, we think it is important that the Medicare beneficiary be enrolled in that kind of program and we do think that accountable health plans, if they meet the right criteria, and most importantly to respond to Mr. Halamandaris's piece, if they are held publicly accountable and certified by government to be that way, we think they will provide the quality and provide the safeguards that many people would be concerned about, and we as hospitals look to the home care community as partners in coming together with—as well as with physicians in forming these kinds of plans to provide that kind of high quality coordinated care.

Mr. WAXMAN. Each of you represent providers who would bear a significant share of the Medicare cuts proposed by the President. You have testified that these cuts would limit access and lower quality for patients. You know that some of these savings proposals were considered by Congress in previous years when they appeared in administration budget requests.

Without effective cost containment in the private sector, and without universal coverage in place, these proposals would certainly continue cost shifting and threaten access for Medicare patients.

My question to all of you is this. If we cover all Americans and limit the growth in premiums for private plans, can we not achieve some significant savings in the Medicare program without the kind of results that each of you forecast?

Mr. POLLACK. Once again from our perspective, we think that we have done just about as much as we can do in terms of the chipping away and the ratcheting down of Medicare provider rates. We are already at a situation where we are about 88 percent of cost. We think, again, that the only way you can find more savings in the system is by changing the way we deliver care and being more efficient in doing it.

The real problems that we see out there in terms of cost drivers that we need to get at tend to be in the area of overlap and duplication, excess capacity and things like that. By changing the delivery system and forcing the type of collaborative arrangements we see in these plans, we think that that is the way to get at those problems that are the cost drivers. We just do not believe a continued chipping away of these current policies will do the job.

You know, if you pay us $5 less to do a gallbladder, that is going to save a lot less over the long term than if we create a system in which one hospital agrees to specialize in one particular area where they are real efficient and another hospital agrees to specialize in another area and you do not have the duplication. We think that is the real way to have a better system and a more efficient and cost-effective one.

Mr. WAXMAN. Mr. Halamandaris, do you want to respond to that question?

Mr. HALAMANDARIS. Yes, sir, Mr. Chairman. The home care agencies of this country under Medicare are reimbursed not at the 80th percentile but at the 67th. Their costs are arrayed throughout the whole country, and a line is drawn at the 67th parallel and any costs above that are not paid and those below are.

The President's plan would drop that to the 50th percentile, or roughly a 11, 12 percent cut in the programs. It would be very difficult to sustain that. If he is worried about being at 80 some percent, imagine our concern at being at 50 percent of cost.

With respect to how to save money, I think we do have some pretty good answers. The home care agencies of this country can provide substantially identical services in both of your geographical areas to one patient under Medicare, another under private duty, and the cost to provide identical services to identical home care clients is half under private duty what it is under Medicare.

Now, why is that? The difference is the red tape, the paperwork that is required under the Medicare program, and that is a real problem. I have had so many nurses who say if I wanted to be an accountant I would have gone to accountancy school, and they are getting out of the provision of services.

If the President can go to one form in terms of the new access plan, why can we not do that under Medicare? As Mr. Wyden said, the paperwork confounds the elderly, and lots of people just throw it away. We need to look at the excess paperwork, the regulations that do not make sense. And I have to say I am responsible because I helped write some of the laws that are now being implemented that have resulted in the massive paperwork.

Mr. WAXMAN. OK.

Ms. Foster.

Ms. FOSTER. Yes, I think there are things that can be done that will lower the amount of Medicare spending, or at least lower the growth in what Medicare is spending for laboratory testing services. And we do discuss this in our written statement.

Rather than implementing a coinsurance requirement or a competitive bidding requirement, and even rather than continued reductions in the national limitation amount, which will now be at 76 percent on January 1, 1995, I think the better answer is to mandate direct billing for all payers. This will have the effect of eliminating incentives to order unnecessary tests and profit from that event.

And the study which I alluded to earlier suggests that that will cause a reduction in the number of tests which are performed for Medicare beneficiaries and, therefore, lower the amount Medicare is spending on utilization.

Mr. WAXMAN. Thank you very much.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I have a question for Mr. Pollack. You state in your testimony on page 3 that $24 billion of Medicare reductions in OBRA 93 came from hospitals and $79 billion of the Medicare reductions in the President's health care bill will come from hospitals as well.

In addition, private sector premiums will be capped, which will effectively preclude cost shifting. Do you have any estimates of what impact this $103 billion reduction will have on hospital closures or the number of people employed by hospitals?

Mr. POLLACK. No, sir, I don't have those. The Medicare numbers that were released today were the first time we have seen them, and in fact when we wrote the testimony we were reacting to a leaked document that had been around. So this is really the first time that we have seen those numbers in their entirety. We will begin the analysis now that we have seen them.

We are, however, very concerned about the impact that they would have and will begin to make that analysis and would be pleased to get back to you with it.

You know, there is no question that it will have a negative impact relative to employment and relative to the infrastructure of the system. And that is why we are very concerned about it.

Mr. GREENWOOD. Is that what the hospital association meant in its press release that said the health security card will not be worth the plastic it is printed on?

Mr. POLLACK. That statement alluded to the fact that there are a lot of problems in the financing of the program as we see it. We are very concerned about what the impact would be of the premium cap. We are very concerned about what the impact would be of the Medicare cuts. We are very concerned about what the impact would be of having the employer mandate, which we support, but having the cap on the private side.

So that statement was in reaction to the concerns on the financing piece.

Mr. GREENWOOD. OK. Let me take up a line of questioning with Mr. Halamandaris. Is that close?

Mr. HALAMANDARIS. Halamandaris.

Mr. GREENWOOD. Halamandaris. Thank you.

It is a line of questioning I probably should not take up but I can't resist. It has to do with your statement in your testimony about health care as a right. Let me precede my question by telling you I am a big fan of home health care and had a very sick little girl who benefited immensely from it.

Mr. HALAMANDARIS. Thank you.

Mr. GREENWOOD. However, this issue of health care as a right seems to be the most pivotal issue in this whole health care debate. When I think of rights, I think of the bill of rights. I define the rights of our citizens of our country on the basis of what our Constitution declares their rights to be, and those rights are all liberties. They are liberties of expression, liberties to go out and pursue things. They are not entitlements. They are not goodies. There is no right to food, clothing or shelter in our Constitution.

And, in fact, if there were a right to health care in this country, it would seem to me that 1 or more of the 37 million folks without health care would simply go to the Supreme Court and go get their rightful right. So do we have a difference of opinion here or are we just using different words?

Mr. HALAMANDARIS. Well, I have to say, Mr. Greenwood, my enthusiasm sometimes gives the impression that I know all the an-

swers, and I don't. I apologize for that. There obviously is a difference of opinion.

The way I see it, and some constitutional scholars that I have read really do believe the basic right is implied now in the Bill of Rights. I would make it specific. And I do accept what you said about the language of the amendments stated in the negative, no law shall be made which shall restrict and so forth.

But I do think that health care is a basic and fundamental right and should be recognized as such as a positive right.

Mr. GREENWOOD. A right you find in the Constitution or a right we find in the laws of nature or?

Mr. HALAMANDARIS. No, a right to be defined by Congress in statute. We did that in the Medicare program. Congress in the preamble to Medicare indicated its view that——

Mr. GREENWOOD. Programs. We would agree on programs. But what you are saying is you would like to see health care a right.

Mr. HALAMANDARIS. Yes, I believe innately it is, but Congress has to recognize it and make it so. It is not found specifically in the Constitution.

Mr. GREENWOOD. Do you see the circular nature of your comments? You are saying it is a right that is not to be found anywhere in any of the law books or documents of the country until the Congress of the United States takes that 1,432 page thing and put it into the document.

Mr. HALAMANDARIS. Congress has to act to make it a reality.

Mr. GREENWOOD. It may some day be a right, but I think we are off on the wrong foot in a national dialogue when we begin by declaring that health care is a right and we have not decided whether we want to make it one or not.

Mr. HALAMANDARIS. I see your point.

Mr. GREENWOOD. Thank you.

Mr. WAXMAN. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Pollack, given that universal coverage would be guaranteed under the Clinton plan or any adjusted plan, I think that certainly under that guaranteed universal coverage hospitals will be assured of payment for the care that they give. Hospitals should, as a result, incur some savings as a result of the President's plan. You say those savings will not occur overnight. Why not and when will they occur?

Mr. POLLACK. Well, first of all, universal access is not going to be phased in overnight. We would like to see it happen as quickly as possible, and the President's plan makes a bold attempt, and probably moves in a more aggressive way than anything else that is out there in making it happen as soon as possible, and we applaud him on that.

But, you know, even if we do get universal access in the way he suggests, there are still going to be people slipping through the cracks, whether it is illegal aliens or whether it is people that exhaust their basic benefit package. We are never going to get it quite as universal as we would all hope it would be.

You know, it is sort of along the discussion, just going on with Mr. Greenwood. As a practical matter, hospitals are the last resort, and the emergency rooms are the last resort. And whether we seek

to achieve universal access or not, it is currently being—we are currently the backstop, and that is why it is so important that we get it done in the right way and in the most efficient way.

Mr. HALAMANDARIS. Right.

Mr. BROWN. Ms. Foster, you made a strong case for requiring all laboratories to bill directly for their services rather than allowing lab bills to be marked up by physicians before being sent to either insurers or to patients. As you point out, this is the rule in the Medicare program.

If such a direct billing requirement were enacted, do you think it would have any effect on preventing laboratory billing practices that results in large extra charges for tests that were ordered as part of a standard battery of tests; and is there any evidence that fraudulent billings are more or less frequent in States that have direct billing laws?

Ms. FOSTER. I have heard nothing that leads me to believe that fraud occurs more often in States that have direct billing laws. In fact, to the contrary. I would suggest that where there is no financial incentive on the part of the test orderer, relationships between the test orderer and the purveyor of the service probably are somewhat purer. So I don't have any reason to think that there is more fraud in direct billing States and I think it is probably to the contrary.

I think there are a number of steps that have been taken in the past year to assure that those kinds of activities are not continuing and that physicians understand what they are ordering and receive what they believe they have ordered. I think this is an issue that has received a great deal of attention and that laboratories are certainly aware of the problem, physicians are aware of the problem, and third party payers are aware of the problem and are taking action to deal with it.

Certainly the American Clinical Laboratory Association, has recently, in fact this past spring, put together a guide of conduct, which each of you has received from us, which does address this very question.

There is one thing which was discussed this morning that I found very interesting, and it was a dialogue between Mr. Vladeck and Mr. Kreidler, which gave me an idea that I think you ought to really very seriously consider, and I think it has applicability to all ancillary services and the role between physicians and ordering patterns and utilization, and that was his remark that he had heard from a physician constituent that the physician ought to be told what service, what the cost of the services he has ordered is when those services are provided by someone other than himself and that ought to be an important component of health care reform so that he is in a position to make good economically sound decision-making with regard to the services he is involved in triggering.

I think that is an excellent idea. And to the extent there is any remaining concern about what direct billing might or might not do with regard to physicians, it would certainly be eliminated if the physician were provided with an explanation of the benefits by the payor, Medicare or the plan, as to exactly what it had paid for; what the tests were and what the amounts were, and send it to the

doctor as well as to the laboratory and the beneficiary of the service. I think that is a fabulous idea and I think you ought to think carefully about that. It is very interesting.

Mr. BROWN. Thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. I want to thank the three of you very much and commend you for your testimony and we will look forward to talking with you further and working with you further.

Ms. FOSTER. Thank you, Mr. Chairman.

Mr. HALAMANDARIS. Thank you.

Mr. WAXMAN. We are being summoned to the House Floor for the purpose of a vote. We will just recess so long as it takes to vote and return so we can hear the last panel.

[Brief recess.]

Mr. WAXMAN. The committee will come back to order.

Our last panel of witnesses represent practicing physicians. Dr. Nancy Dickey is a Member of the Board of Trustees of the American Medical Association; Dr. J. Leonard Lichtenfeld is the Secretary-Treasurer of the American Society of Internal Medicine; and Dr. Terry Hicks is the Associate Chairman of the Department of Colon and Rectal Surgery at Ochsner Clinic in New Orleans, and he is testifying today on behalf of the American College of Surgeons.

I want to welcome you all to our hearing today. Your prepared statements will be in the record in full without objection, and we would like to ask you to limit the oral presentation to no more than 5 minutes.

Dr. Dickey, why don't we start with you.

STATEMENTS OF NANCY W. DICKEY, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY JANET K. HORAN, LEGISLATIVE COUNSEL; J. LEONARD LICHTENFELD, MEMBER, EXECUTIVE COMMITTEE, AMERICAN SOCIETY OF INTERNAL MEDICINE; AND TERRY C. HICKS, ON BEHALF OF AMERICAN COLLEGE OF SURGEONS

Ms. DICKEY. Thank you very much, and appreciate your endurance. It has been a long day.

My name is Nancy Dickey, and I am a practicing family physician in Richmond, Tex., and a Member of the Board of Trustees of AMA. With me is Janet Horan from the association's Division of Federal Legislation.

As a starting point, the AMA never expected that we would agree or disagree with all of the elements of any proposal for health system reform. Today, we are focusing on an area where we disagree, and I am pleased that the committee is devoting careful attention to the President's Medicare proposals. These proposals include massive spending cuts and an overhaul of the RBRVS.

We are very concerned that these proposals undermine the fundamentals of physician payment reform. They threaten access for Medicare beneficiaries and send exactly the wrong signals about the degree to which physicians and other Americans can expect their government to honor commitments made as part of health system reform.

We share the concerns expressed in the recent bipartisan letter to the President from Members of this House of Representatives that stated that the administration's proposals coupled with OBRA 93 and 90 will continue to push many health care providers toward the brink of financial disaster and risk eroding access to care for millions of poor, elderly and disabled Americans.

The Medicare part B cuts proposed in the plan violate fundamental elements of Medicare physician payment reform. They inject instability and complexity into a system that was instituted to provide just the opposite. They reflect a seeming and unseemly cynicism about physicians as deep pockets from which health system reform can be funded, and a promise to dramatically accelerate the downward spiral of Medicare physician payments and the increased cost shifting pressures that are already occurring.

We have profound concerns about the broad implications of these cuts, and I would like to take a minute to look at a couple of them. Let's look at preliminary simulations on the establishment of a cumulative Medicare volume performance standard to replace the current MVPS. The penalty for exceeding the MVPS compounds each year, and the concept of individual physician responsibility for the volume and intensity of services, becomes totally irrelevant in the confusion that will come about.

Second, the proposed 1995 rollback of the 1994 conversion factor by 3 percent for all services, except primary care, abrogates the agreement made when we worked with Congress to create the MVPS and would lead to a future of diminishing real payments for services provided to Medicare beneficiaries.

The establishment of an elaborate high cost hospital staff MVPS certainly would violate the concepts of security, responsibility, quality and choice. This proposal would shift both hospital and physician payment incentives to reward the provision of least care for their patients. Physicians should not be penalized for being advocates for their patients or for being willing to take care of the high cost, highly complicated patients that lead to higher hospital costs.

Competitive bidding. It is just not an appropriate means to pay for professional health care services that are tailored to dynamic and highly individual needs. Patients and physicians who may be dissatisfied with the care giver should be able to change if necessary, and in the competitive bidding situation they lose the option of going to a new provider for services without regard to what the winning bid is.

I work in a low-income clinic and we have some experience with competitive bidding. We sent our Pap smears out for competitive bidding and, indeed, the bid was much lower. But it took 30 days for them to get a report, and I could never talk to the pathologist that read the report, and we finally decided a couple dollars more per Pap smear was well worth the quality of what we got, and our patients could actually get their reports in a timely fashion.

In conclusion, we want the committee to know that physicians are eager to adapt to and participate in a revamped American health care system. Again, working in a low-income clinic, I can assure you I get daily experience in the needs for how the system must be changed. However, change ought to be accomplished in a

manner that builds on what works in our system without destroying it.

If the goal behind the Medicare proposals is to save money and squeeze the program out of existence, then the administration should be up front about that and tell the Medicare beneficiaries that is what they are trying to do and simply put them into the mainstream. But if they are trying to do it in the interest of saving money without telling the beneficiaries what might be lost, then we think they are being dishonest about the process.

Mr. Chairman, I thank you for the opportunity to testify today, and I will be happy to answer any questions.

Mr. WAXMAN. Thank you very much, Dr. Dickey.

[Testimony resumes on p. 507.]

[The prepared statement of Ms. Dickey follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health and the Environment

Committee on Energy and Commerce

U.S. House of Representatives

Re: Medicare Proposals From "The Health Security Act"

Presented by

Nancy W. Dickey, MD

November 18, 1993

Mr. Chair and Members of the Committee:

My name is Nancy W. Dickey, MD. I am a practicing family physician from Richmond, Texas and a Member of the Board of Trustees of the American Medical Association. With me today is Janet Horan, JD, from the Association's Division of Federal Legislation. The AMA appreciates this opportunity to appear today to discuss the subject of Medicare proposals from President Clinton's "Health Security Act."

The American Medical Association wholeheartedly supports the directions and goals of the Clinton Administration in its efforts to move the nation to a point where health care concerns will focus on maintaining health, and where apprehension over obtaining needed health and medical care services will become a problem from the past. We agree with all six of the yardsticks set out by President Clinton as the basis for measuring proposals for health care reform: security, simplicity, savings, responsibility, quality and choice. We are proud of the fact that these principles were the very same starting points used by the AMA in the

development of our health system reform proposal, *Health Access America*. This is why we were eager to work with the new Administration in its efforts to develop a blueprint that would provide guidance for this Congress in enacting health system reform legislation.

The AMA never expected that we would agree or disagree with all elements of any proposal for health system reform. We are pleased that the public process of Congressional hearings and deliberations will allow the multiple elements that will constitute health system reform to be subjected to scrutiny based on the President's six points. We are pleased that the Committee is devoting careful attention to the Medicare proposals, set out in the President's Health Security Act, which include massive spending cuts and an "overhaul" of the Resource-Based Relative Value Scale (RBRVS). We are very concerned that these proposals fail the measuring criteria. They undermine the fundamentals of physician payment reform, threaten access for Medicare beneficiaries, and send exactly the wrong signals about the degree to which physicians and other Americans can expect their government to honor commitments made as part of health system reform.

Mr. Chairman, in testifying today and as we have testified in the past on budget proposals, we want to make it clear that many of these Medicare proposals would be opposed regardless of their context. Also, we do not believe that general health system reform should be financed through Medicare program reductions.

In addition to multiple problems with many of the individual Medicare proposals, we share the concerns expressed in the November 4, 1993, bipartisan letter to the President from forty-one (41) Members of this House of Representatives:

> "Medicare and Medicaid savings of the magnitude that are contemplated in your proposal, coupled with those already enacted as part of the OBRA 93 and OBRA 90, will continue to push many health care providers toward the brink of financial disaster and risk eroding access to care for millions of poor, elderly and disabled Americans.

> It is unclear whether the rigid, formula-driven budget caps that your proposal would impose on the Medicare and Medicaid programs bear any relation to the actual health needs of a community, or if they will be flexible enough to respond to changing and unforeseen circumstances."

If these Medicare cuts and modifications were to be enacted, that legislation would fail virtually every one of the yardsticks held up by President Clinton. And even though a substantial amount of savings would be attained, we are concerned that this would be achieved at far too great a human cost. As further stated in the Representatives' November 4 letter:

> "... the level of reductions you have suggested in your proposal may place these important programs for the poor, elderly and disabled in severe financial jeopardy."

With these thoughts in mind, we offer the following specific comments concerning the Administration's proposed Medicare Part B changes.

MEDICARE PART B PHYSICIAN SPENDING CUTS

The Medicare Part B cuts proposed in the Plan violate fundamental elements of Medicare physician payment reform. In fact, the only one of the President's six principles that these proposals do not violate is "savings." They inject instability and complexity into a system that was instituted to provide just the opposite. They reflect a seeming and unseemly cynicism about physicians as "deep pockets" from which either reduction in the deficit or health system reform can be funded. They promise to dramatically accelerate the downward spiral of Medicare physician payments, increasing cost shifting pressures. Thus, physicians and patients must have profound concerns about the broad implications of these cuts. If these changes were enacted, this abrogation of the OBRA 89 agreements would raise questions for physicians about whether the very fundamental agreements reached to pass health system reform will be honored.

Establishment of Cumulative Expenditure Goals for Physician Services

Using fiscal year 1994 as a base, this provision would compare the two factors of cumulative Medicare Volume Performance Standards (MVPSs) and cumulative actual expenditure increases to determine the annual default conversion factor update. The conversion factor update for a category of physicians's services for a year beginning with 1996 would increase or decrease by the percentage by which the cumulative increase in actual expenditures for that category of physicians' services for that year was less than or greater than the MVPS for that category of services for that year.

Preliminary simulations of this proposal demonstrate that the cumulative MVPS will almost certainly send Medicare physician payments into a tailspin from which they will never recover. This new "update" process would be compounded by the increases in the performance standard factor (the OBRA 93 arbitrary 4% reduction from projected spending), the proposal to substitute real Gross Domestic Product (GDP) for the real data on historical medical volume and intensity, and the proposed elimination of any floor on payment reductions. With expenditures highly likely to come in over the target in future years, fees probably would be reduced each year and there would be no limit on this reduction. The penalty for exceeding the MVPS compounds each year, and the concept of individual physician responsibility for the volume and intensity of services becomes irrelevant in the confusion.

Use of Real GDP to Adjust for Volume and Intensity

The Clinton proposal would replace the medical volume and intensity factor from the MVPS and replace it with the average per capita growth in the real GDP for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for primary care services). While we do appreciate the improvement this represents over the September 7

draft, that proposed elimination of this factor entirely, this will only serve to further drive down updates. In general, growth in real GDP per capita has been far below historical levels of medical volume and intensity growth. For 1986-1992, the average annual growth in real GDP was 2.30% while the average growth in real volume and intensity (as measured by the Medicare Trustees) was 6.94%.

This proposal improperly assumes that the appropriate rate of growth for health care expenditures is GDP. This presumption simply flies in the face of the fact that the provision of health and medical care occurs in a highly service intensive sector of our economy where the labor and the costs of services historically exceed the costs of goods. And, in truth, the costs associated with providing this care also should not be unexpected. These costs, much like educational expenses, historically have risen at a rate above the rate of growth in the GDP, the consumer price index, and other economic measures. Furthermore, the technology intensive nature of health care today and in the future acts as an accelerant and is a further significant reason why there is the gap between real GDP and real medical volume and intensity. This gap also represents a real demand for the services from which our patients benefit.

Nevertheless, the proposal arbitrarily would limit program growth leading to spending increases far below even nominal GDP growth. This proposal is unacceptable, especially when coupled with the OBRA 93 reduction in the performance standard rate of increase from 2% to 4% for 1995 and beyond. This proposal would eliminate any remaining shred of credibility for the MVPS as a reasonable guideline for the evaluation of spending on physician services.

Repeal of Restriction on Maximum Reduction Permitted in Default Update

The floor on MVPS payment reductions was an integral part of the OBRA 89 compromise. It served to protect physicians and patients from excessive and automatic application of the MVPS formula. Nevertheless, OBRA 93 just three months ago increased the maximum MVPS-related payment reduction from 3% to 5%. This change has already eroded the floor on MVPS-related adjustments that was an integral part of the OBRA 89 agreement. By the outright elimination of this floor, the other changes set out in the Administration's proposal would combine to wreak maximum havoc on physician payment reform.

Reduction in Conversion Factor for Physician Fee Schedule for 1995

Following on OBRA 93 reductions in the 1995 conversion factor, the Plan proposes even steeper reductions in the conversion factor update for non-primary care services in 1995. It would allow the full 1995 default update only for primary care services and would actually roll back the 1994 conversion factor levels by 3% for all other services.

Given that all indications are that 1993 actual Part B physician spending will be well below the 1993 MVPS, especially for surgical services, it appears that this proposal will once again prevent physicians from realizing promised payment increases. This provision abrogates the agreement that created the MVPS, and it would be little more than a jump start to a future of diminishing real payments for services provided Medicare beneficiaries. Furthermore, as charges for services go down, demand can be expected to increase, further exacerbating this problem.

Limitations on Payment for Physicians' Services in High-Cost Hospital Medical Staffs

The Plan would create an elaborate scheme of hospital medical staff MVPSs. In general, this provision would require the Secretary of HHS to project a hospital-specific per admission relative value for the next year by October 1 of each year (beginning with 1997) for each

hospital and to estimate whether or not this hospital-specific projected relative value will exceed the allowable average per admission relative value applicable to the hospital for the following year. The allowable average per admission relative value is set as a percentage of the median 1996 hospital-specific per admission relative value and is set differently for urban (120% for 2000 and beyond) and rural (140%) hospitals. It would be adjusted for case-mix, disproportionate share, and teaching status.

If any overage is projected, the Secretary would reduce all payments made for hospital inpatient services provided by physicians on that medical staff by 15%. Actual and projected shortfalls would not be reconciled until October 1 of the year after any reductions are made (i.e., October 1, 1999 for reductions made relating to services provided from January 1 - December 31, 1998). Where the actual average per admission relative value for the medical staff did not exceed the allowable average per admission relative value applicable to the medical staff, the Secretary would reimburse the medical staff for the amount by which payments were reduced.

Where reductions are made, and where the adjusted expenditures were less than 15% above the allowed level, the medical staff would not recoup the full amount by which its overage was less than 15%. If the shortfall is less than 10%, the Secretary would reimburse the medical staff for the difference between 10% and the actual percent by which the staff exceeds the limit—that is, if the medical staff exceeded the limit by 5%, it would be reimbursed 5% and would be penalized 10%. If the shortfall exceeds 10%, none of the withhold would be returned to the medical staff—that is, if the medical staff exceeded the limit by 10.1%, it would be penalized 4.9%.

The AMA is very concerned by the many negative implications of this proposal. It would:

- violate the principle of simplicity by creating a new and onerous regulatory structure;
- require the Secretary to project hospital-level average relative values per admission and, based on these projections, would withhold the full 15% of all payments for medical care even if the projected overage is 1% or even .1% (The MVPS experience shows the limits of the nascent "science" of volume/intensity projections.);
- delay reconciliation until October 1 of the following year, even though relevant data would be available by April 1;
- make only partial repayment to physicians for excessive withholds;
- establish specific standards for "high cost" medical staffs in advance of any provisions for public notice and comment;
- assume that DRG-based case mix adjustments were appropriate for physician payments;
- require medical staffs to establish expensive fiscal and administrative structures to monitor care using measures that may not be appropriate for such a purpose; and
- violate agreements on MVPS-structure that were made as a result of OBRA 89.

Finally, this proposal would shift both hospital and physician payment incentives to reward the provision of the least care. Physicians as well as other care givers should not be penalized for advocating care for their patients. This certainly violates the principles of security, responsibility, quality and choice.

Elimination of Medicare Balance Billing

The Administration proposes to impose mandatory assignment on all Medicare Part B claims as of January 1, 1996. The AMA strongly protests this change. Again, this is a major violation of the agreements reached in reforming physician payments under Medicare just four years ago. This also is inconsistent with the Physician Payment Review Commission's (PPRC) 1989 recommendations to the Congress. This change would exacerbate current cost shifting pressures. Also, as previously noted, this type of action will increase Part B spending as patient out-of-pocket costs are reduced.

RBRVS OVERHAUL

Section 4115 of the Plan, titled Medicare Incentives for Physicians to Provide Primary Care, proposes what can only be referred to as an "RBRVS overhaul." This provision addresses:

- Medicare payment for office consultations;
- payment for office visit work and practice expense relative value units (RVUs);
- resource-based RBRVS practice expense values; and
- payment for services with high ratios of work RVUs/time.

In general, these proposals manipulate the RBRVS to reach a predetermined outcome—a substantial increase in the Medicare payment levels for primary care services. (Under current law, primary care services include office visits, emergency department services, and several other categories of visits; they do not include consultations, hospital visits, or critical care.)

The AMA is committed to an RBRVS that is based on accurate measures of physicians' resource costs. We have made a major commitment to organize physician groups into a Relative Value Update Committee (RUC) in order to maintain the RBRVS's scientific validity. HCFA already relies on the RUC results in the RBRVS update process. (We would be pleased to provide further information on this activity for the Committee and its staff.)

The RBRVS should be based on, and only on, accurate measures of physicians' resource costs. RVUs should not be revised solely to achieve inter-specialty payment goals. Relative value adjustments outside of the normal RUC and refinement processes, solely to achieve inter-specialty payment redistributions, threaten the RBRVS and its continued viability, especially for use beyond Medicare. Finally, the AMA continues to have concerns about funding specific policy changes by reducing RBRVS RVUs. We continue to favor a separate Medicare Adjustment Factor to make such budget neutrality adjustments.

Resource-Based Practice Expenses

This proposal calls for the Secretary of HHS to increase practice expense (PE) RVUs for primary care services by 10% starting in 1996, with RVUs reduced for all other services by a budget neutral amount. It also calls on the Secretary to establish a resource-based PE method that could be implemented in 1997 and to report to Congress by June 30, 1996, on the methodology for this system, including a presentation of the data utilized in developing the methodology and an explanation of the methodology.

The AMA continues to support a PE study by the HHS Secretary. Prior to completion of the RBRVS transition in 1996 and without the results of this study, we oppose implementation of resource-based practice expense RVUs. Although a 10% increase in the primary care practice expense RVUs would be consistent with current projections of the PPRC's resource-based practice expense method, it would result in payment reductions for all other services regardless of whether the PE RVUs would increase or stay unchanged under the ultimate RBRVS PE methods. This proposal, on top of the just enacted OBRA 93 updates that favor primary care services, is premature.

Office Consultations

This proposal would cut Medicare payment rates for office consultations to equal those for office visits beginning in 1996. It would use resulting savings to increase payments for office visits. Under this proposal and based on 1993 national (no geographic adjustment) RBRVS amounts, it would be possible that payments for new patient office visits would increase by 5.5% and payments for office consultations would decrease by 23-31%. Medicare payments to specialties providing a substantial share of primary care services would rise—family physicians (2.1%), internists (.2%) and allergists (1.3%). Payments to other

specialists, including cardiologists (-1.3%), gastroenterologists (-2.3%), and neurologists (-6.5%), would fall.

This provision would make large cuts in current consultation payments to fund small office visit increases, and it would be contrary to PPRC conclusions that consultations should have higher average work intensities.

Primary Care Work RVUs

This proposal would increase office visit work RVUs by 10% for "office visit pre- and post-time." The RVUs for all other services would be reduced to fund this change, as with the PE RVU increase. The assumption is that all pre/post-service time is not included in the current RBRVS values. We are concerned that the methodological or data basis for this change is unclear. Time needs to be reflected accurately by the RBRVS. For example, case management services and telephone consultations are not fully accounted for in pre/post time.

Reduce the Work RVUs of "Outlier Intensity" Procedures

Beginning in 1996, this proposal would require the Secretary to reduce the work RVUs for "outlier intensity" procedures, or classes of procedures, that have a high ratio of work RVUs per procedure time. "Savings" would be used to increase payments for primary care services. This proposal resembles the approach in OBRA 93 to reduce "outlier" PE RVUs. No specific threshold or level of reduction is suggested, nor is there a publicly available database with this information.

This proposal would simply assume that "outlier" intra-work RVUs are inappropriate, even though they were developed by the same Harvard RBRVS method used for the overall RBRVS and have not been altered by HCFA's refinement process. The AMA opposes such an arbitrary series of reductions outside a formal RVS update and refinement process. The RUC currently is working on methods that could be used to identify overvalued services.

This proposal could distort the relative values for both outlier services and primary care services. It could also set a precedent for non budget-neutral reductions for other categories of "overvalued" services.

COMPETITIVE BIDDING

The "Health Security Act" calls for the use of competitive bidding as a mechanism to pay for various health and medical services. In addition to broad authority to determine what would be purchased through competitive bidding, the proposal specifically calls for this method to be used as the payment mechanism for MRI and CT scans (including physician interpretation), and clinical diagnostic laboratory services. If competitive bidding does not result in a 10% reduction in the fee schedule for clinical laboratory services, the Secretary would be required to reduce such fees to achieve the 10% reduction.

While competitive bidding may be appropriate as a purchasing mechanism for goods and services where quality is readily discerned or generally does not vary, it is wholly inappropriate for the purchase of professional services that are tailored to dynamic and highly individual needs. Competitive bidding is a particularly inappropriate mechanism to purchase medical and health care services, and it violates the principles of security, responsibility, quality and choice.

Where items are standardized or easily specified, such as nuts and bolts, competitive bidding is a logical mechanism for choosing the supplier of goods. However, where professional services are being purchased, even what appears to be a "standardized" service may not be so easy to quantify.

Competitive bidding may result in a reduction in the quality of and access to the service sought. The potential for reduced quality is particularly real in the health care sector

of the economy where the services are unique due to many variables, including the involvement of individual patients, physicians, hospitals, and other health care providers.

While initial savings may be generated by competitive bidding, the savings may be counterbalanced by a loss in the quality of health care services and diminished access to care where the "winning" bidder is remote from the patient, or where "non-winners" cut back on their provision of the particular service. Such savings are short-sighted and carry the high potential for a negative health care outcome.

We continue to maintain that the competitive bidding mechanism for selecting a provider of such distinct and individual care services is just not appropriate. Serious questions that ultimately revolve around the quality of care provided readily arise:

- How would the quality of the provider bidding on the services be determined?
- Would providers be allowed to bid on services that are outside of their current area of service provision?
- Would turn-around time be affected by the bid price?
- Will patients be inconvenienced or costs increased if physicians are unable to provide or attain special services through their offices or other settings?
- Would the competitive bid process force losing competitors out of business, thereby limiting access to care?
- How is the bid area to be defined? What would be the impact of a national or regional provider of services on the bid? How would such a provider participate in the bid process?

In addition to the specific questions raised here, serious consideration must be given to the future of the health care industry in an area where a competitive bid demonstration is allowed. Under the current system, a large number of entities may deliver services, price information should be readily available, and physicians and their patients are free to elect to have services provided by one provider as opposed to another. Where there is dissatisfaction with the provider services, physicians and their patients should have the option of voting with

their feet and going to a new provider. Under a competitive bid system, this ability will be either eliminated or greatly diminished. There has been some experience in this area with the competitive bidding of pap smears by some states. Unfortunately, the results were often poor quality. As a result, those contracts have been terminated.

Under a competitive bid program, dissatisfied beneficiaries are unable to exercise true freedom of choice. Eliminating freedom of choice eliminates a major quality check that oftentimes is a patient's or referring physician's only significant option in directing care: the ability to seek care from the complete range of physicians and other health care providers.

We urge rejection of competitive bidding as a means to purchase unique health and medical care services. Being a low bidder carries no guarantee of quality. In a truly competitive market, purchasers are free to elect to receive services from the provider of their choice. This would not be the case in a competitive bid environment and the end result is one where it is the potential recipient of the services who may suffer. Our patients stand to be the ultimate losers from such a direction.

CENTERS OF EXCELLENCE

President Clinton's proposed "Health Security Act" would provide the Secretary with broad authority to enter into contracts, using a competitive process, with "centers of excellence." This would be done for cataract surgery and for other services deemed appropriate by the Secretary. All payments made to such centers, including payment for physicians' and other professional services would be made directly to the center. The proposal is silent as to criteria for or the definition of "centers of excellence."

The AMA questions the feasibility of establishing "centers of excellence" using a competitive process as a way to either contain Medicare costs or improve quality. Several questions arise in considering the "centers of excellence" proposal:

- How many of these "Centers" will be established in a given geographical area?

- How far will Medicare beneficiaries be required to travel to receive health care services at these centers, and how will follow-up care be provided?

- If key individuals on the medical staff in one of these centers leave, does the center lose it "excellence" rating?

- If a Medicare beneficiary is unable or unwilling to receive care through a convenient "center of excellence" for a particular service, will reimbursement be denied?

- What happens if the best health care facility providing a specific health care service refuses to bid on being designated a "center of excellence"? Will Medicare beneficiaries be denied the services of this facility?

Furthermore, physicians who are not providing services through one of these "centers of excellence" and other non-designated facilities could be perceived by the public as providing poor quality services. This would be a serious misperception and an unfortunate result of establishing these "centers of excellence." The AMA believes that too many problems arise to justify establishing "centers of excellence" as a formal part of the Medicare program.

CONCLUSION

The American Medical Association regrets having to appear before you with so many negative comments about the President' proposal to restructure Medicare as part of health system reform. If the goal behind these Medicare proposals is to save money and to squeeze the program out of existence, then the Administration should be upfront and simply close down the program and "mainstream" the over 30 million Medicare beneficiaries.

We want the Committee to know that physicians are eager to adapt to and participate in a revamped American health care system. However, change should be accomplished in a manner that builds on what works in our system without destroying it. Finally, we urge you to consider each of the multiple Medicare proposals in the context of security, simplicity, savings, responsibility, quality and choice. We just do not believe that the proposals before you today can pass this scrutiny.

Mr. WAXMAN. Dr. Lichtenfeld.

STATEMENT OF J. LEONARD LICHTENFELD

Mr. LICHTENFELD. Thank you, Mr. Chairman.

Good afternoon. My name is Lynn Lichtenfeld. I am a member of the Executive Committee of the American Society of Internal Medicine. I am a general internist in Baltimore, Md. It is a pleasure for me to be here today to share with you ASIM's views on the Medicare proposals in the administration's reform program.

First, ASIM reiterates its strong support for comprehensive health system reform that includes most of the key elements of the President's plan. Even where we disagree, ASIM intends to offer constructive alternatives.

ASIM supports the President's proposals to finance health system reform through higher taxes on tobacco products and by requiring all employers to contribute to their employees' health insurance costs.

We are concerned, however, about proposed cuts in Medicare and are not persuaded that these cuts can be achieved without compromising patient care. It also does not make sense to us to pay for new expanded Medicare benefits by making cuts that may limit access to other services already covered by Medicare.

Other concerns ASIM has about the Medicare proposals contained in the Health Security Act involve the impact of the competitive bidding for lab services, the reduction in payments for services of hospital medical staffs, mandatory assignment for all part B services, and the provision of direct payment and coverage for nonphysician providers.

ASIM would also remind this committee that the Medicare program is already the subject of almost $56 billion in cuts this year as a result of the Omnibus Budget Reconciliation Act of 1993. Proposals put forth by some Members of Congress to enact further reductions in this program separate and apart from health system reform would do severe damage to Medicare and resolve none of the problems in the current system.

ASIM strongly agrees with the objective of substantially improving Medicare's payments for undervalued evaluation and management services. We support increasing payments for office visits and other primary care services by an amount at least equal to that proposed by the administration.

The administration proposes to accomplish these changes by increasing the RVU's for certain visit services. To counter concerns that this would further distort the RBRVS, ASIM proposes the equivalent amount of increase could be accomplished by mandating bonus payments or by creating a separate adjustment factor for such visit services.

ASIM specifically supports the administration's proposals to establish a RBRVS method for overhead RVU's and mandating interim increases in the practice expense RVU's for office visits. ASIM urges implementation of the new method no later than January 1997.

I would like to take a moment to commend the Energy and Commerce Committee for its proposal developed earlier this year to affect this change and for your efforts to include it in the budget rec-

onciliation bill. We also suggest that there should be an increase in bonus payments for primary care services provided in underserved areas. There should be a provision for a higher expenditure target rate of growth for the separate primary care services target.

ASIM believes that the separate VPS should be expanded, however, to all evaluation and management services and that a higher floor should be established on the minimum updates for such services. RVU's should be reexamined for work in office visits to account for work that is not adequately recognized in the current RVU's, such as the work required for a patient with multiple chronic illnesses, lower intensity case management services, and prolonged physician visit services.

ASIM does not support the proposal to redistribute office consultation RVU's to all office visits. Office consultations do involve more resources than office visits and should appropriately have a higher work RVU. We do support an increase in payment for office visits by the amount that would be accomplished by this proposal, but by lowering payments for all non-E/M services rather than reducing the payments for office consultations.

We agree that the number of physicians being trained in primary care should be increased significantly, but suggest that a goal rather than an absolute percentage limit may be more achievable and realistic.

ASIM also agrees with the creation of a national body reporting to HHS to make recommendations on the number of training positions in each specialty, and we previously endorsed Chairman Waxman's bill which includes such a submission.

Two omissions in the President's proposal which concern ASIM are the lack of any overall cap on the number of residency positions and the failure to include criteria that must be considered when slots are allocated to each training program.

This concludes my statement. ASIM commends President Clinton for what he has accomplished so far and reiterates its willingness to work with the administration, Congress, and others to achieve enactment of legislation to bring about comprehensive health system reform. Thank you.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Lichtenfeld follows:]

American Society of Internal Medicine

Testimony to the

House Energy and Commerce Committee

Subcommittee on Health and the Environment

November 18, 1993

Introduction

Good afternoon. I am Dr. J. Leonard Lichtenfeld, member of the executive committee of the American Society of Internal Medicine (ASIM). ASIM is a national medical specialty society representing physicians who specialize in internal medicine and its subspecialties. Our policies are established by our House of Delegates, which consists of democratically-elected internists from state and subspecialty societies. I am pleased to be here today to discuss with the members of this committee ASIM's views on many of the proposals for Medicare contained in the administration's reform plan and other issues related to Medicare in the context of health system reform.

Building a consensus for reform

First, however, I would like to reiterate what ASIM has said to other Congressional committees and that is that we believe the time has come for comprehensive, health system reform and we will do everything we can to keep the process moving forward. ASIM believes that the consensus for health system reform is a fragile one. Most Americans seem to want change, but they also fear what they will be asked to give up to achieve it. Physicians are no different. The consensus for reform will shatter if all that people hear is what they will lose from health system reform, rather than what we all stand to gain.

The way to counteract the negativism that threatens to shatter the consensus for reform, we believe, is for each of us to take a constructive "let's get it done" approach. ASIM for its part will continue to emphasize what is good in the President's proposal--as well as in the proposals of others. When we disagree with the proposals offered by the President or others, we will seek to offer constructive alternatives that could form a basis for reconciling our differences, rather than just standing in opposition.

Overall Views on Health System Reform

Just a few weeks ago ASIM's democratically-elected House of Delegates, representing internists in each state and subspecialty, reviewed several reports on health system reform and adopted, or reaffirmed, broad policy to guide ASIM's efforts in the debate. ASIM's House of Delegates adopted policies supporting a balanced and constructive approach to health system reform, one that I believe stands the best chance of strengthening the consensus for reform. The internists represented by our House of Delegates reaffirmed their commitment not only to the goal of comprehensive reform of the health care system, but to achieving that goal as expeditiously as

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possible. Incremental reforms that fall short of guaranteeing that all Americans have access to an affordable standard benefits package are not acceptable.

Internists also agree with many of the President's proposals to achieve universal access, even though some of the elements of his plan have raised questions or concerns. Where we disagree, our delegates voted to come to the table with constructive alternatives in an effort to bridge our differences. There are also elements of some of the other proposals that are being considered by Congress that have merit and should be included in the final legislation reported out by Congress. ASIM believes that comprehensive reform should include the best elements of each of the proposals that are being considered by Congress, rather limiting consideration to only one approach.

The Clinton Plan and Medicare

ASIM's House of Delegates endorsed many of the key elements of the President's proposal, at least as they were outlined in the draft plan. For purposes of this statement, I will focus on those related to the Medicare program.

Financing Health System Reform

ASIM supports the President's proposals to finance health system reform by increasing taxes on tobacco products and by requiring all employers to contribute to the cost of purchasing health insurances. Internists are concerned, however, about the proposed cuts in Medicare that are required in the President's plan, and that are also required to a somewhat lesser extent in several of the other legislative proposals. We are not persuaded that these cuts can be achieved without compromising patient care. Many internists have already reported that they are unable to accept new Medicare patients because of low levels of payment. Even though the administration proposes to exempt some primary care services from the reductions, some of the proposed cuts would be highly detrimental to internists. Even though some of the money saved in Medicare would be used to finance prescription drug benefits and long-term care, it doesn't make sense to pay for new expanded Medicare benefits by making cuts that may limit access to other services already covered by Medicare.

ASIM would remind this committee that the Medicare program was already the subject of almost $56 billion in cuts this year as a result of the Omnibus Budget Reconciliation Act of 1993. Proposals put forth by some members of Congress to enact further reductions in the program -- several of which are the same as those included in the Health Security Act -- separate and apart from health system reform, would do severe damage to Medicare and resolve none of the problems in the current system. In the absence of reform, such reductions would lead many physicians to conclude that retirement is the only real option for them or to limit the numbers of Medicare patients in their practices.

As an alternative to further cuts in Medicare, ASIM favors raising the proposed tax on tobacco by a greater amount than that proposed by President Clinton, increasing taxes on alcoholic beverages, capping the deductibility of employer contributions to the purchase of health insurance, and only if necessary, increasing personal and payroll taxes.

A cap on the deductibility of an employer's contribution to the purchase of health insurance coverage is a feature of the Managed Competition Act of 1993 and the Senate Republican Health

Task Force proposal. Unlike those proposals, which would unfairly disadvantage fee-for-service plans that offered free choice of physician by setting the cap at the premiums of the lowest bidding plans, ASIM believes that the cap should be set at the average or median premium of competing plans. A tax cap would introduce much greater price sensitivity into the system, thus helping to slow the escalation in health care costs. Plans that raised their premiums to an amount that is considerably above the cap would be at a market disadvantage, which would act as an incentive for plans to restrain premium increases. Regulation of health plan premiums would not be necessary if the tax cap introduced market forces that would restrain premium increases.

Other Concerns About the Administration's Medicare Proposals

Other concerns ASIM has about the Medicare proposals contained in the Health Security Act involve the impact of the competitive bidding for lab services, the reductions in payment for services of hospital medical staffs, mandatory assignment for all Part B services and the provision of direct payment of and coverage for non-physician providers.

CLIA regulations and restrictions on the abilities of physicians to use shared laboratory facilities have had an adverse impact on physicians' provision of in-office laboratory services. Payments under Medicare for lab services are already so low as to barely cover physicians' overhead costs. Bidding out clinical laboratory services and requiring that payment only be made for services furnished via competitive bid will prevent physicians from delivering these services in their offices thus destroying patients' easy access to a major diagnostic service. In addition, it does not make sense to ease the CLIA regulatory burden on physician office labs, as the administration's proposal would do only to put such a major obstacle in the way of physicians providing these services in their office laboratories.

The creation of relative values for hospital admissions that could then be reduced for all hospital medical staff would, on its face, be unfair in its application to those on the medical staff who practice conservatively. In addition, this would also reduce already undervalued Medicare payment rates for evaluation and management services.

Internists believe that the prohibition on balance billing under all plans, including Medicare, is equivalent to price controls and all-payer rate setting. ASIM believes that price controls can lead to maldistribution problems by locale and specialty, as has been the case with Medicaid and, to a growing extent, Medicare; reduce the incentives for physicians to gain more skills and knowledge or improve services, since those who invest in such improvements are limited to the same fees as those who do not; inappropriately restrict the right of physicians and patients to contract freely for services; and could result in the kind of "black market" for health care services that is found in virtually every country that has imposed rate-setting on physician services.

The broadening of coverage of and reimbursement for services by all advanced practice nurses (not simply those in rural settings) who work "in collaboration with" a physician should be considered within the overall philosophy of integrated and coordinated systems of care espoused by so many reform proponents. Depending on how the term "collaboration" is interpreted, any loosening of the connection between physician and non-physician providers that leads to a fragmentation of care will only be detrimental to patients.

Improving Payments for Primary Care

ASIM is pleased that the administration's proposals include many of the incentives for primary care recommended in a paper published by ASIM earlier this year. We agree with the objective of substantially improving the Medicare rates for undervalued evaluation and management services. ASIM offers the following specific comments and recommendations on the way that the administration proposes to increase payments for primary care services:

Establish a RBRVS-method for overhead RVUs: ASIM fully supports this proposal. We urge the administration to seek a legislative mandate for implementation of the new method no later than January, 1997. We believe that an interim increase in the practice expenses for primary care visits of <u>at least</u> 10 percent is justified by the objective and independent studies that have been done to date by the PPRC, Hsiao, and HCFA, all of which concluded that practice expense RVUs for visits are grossly undervalued. Here, I would like to take a moment to commend the Energy and Commerce Committee for its proposal developed earlier this year to effect this change and for your efforts to include it in the budget reconciliation bill. Regrettably, these provisions were dropped from OBRA '93 for reasons other than the substance of the provision.

Provide a higher expenditure target rate of growth for the separate primary care services target: ASIM supports this recommendation, but believes that consideration should be given to expanding the separate VPS to all evaluation and management services, instead of just "primary care" visits; making the adjustment through a separate adjustment factor, as explained below, rather than through the conversion factor; and by setting a higher default update for services in the separate visit category. A higher default update for services included in this category, such as by setting the minimum update at the Medicare economic index (MEI), would assure that payments for primary care visits at least keep pace with inflation, instead of losing ground. Otherwise, even with a separate and higher expenditure VPS for primary care services, primary care visits would be at risk of being eroded by inflation if actual expenditures exceed the VPS. (Under ASIM's proposal, if expenditures fell below the VPS, primary care would get an update that is higher than the MEI. They could not, however, ever get less than the MEI). A higher default update is especially important since OBRA 93 lowered the default floor for <u>all</u> services, including primary care visits. We understand that for ASIM's recommendations to be accepted, the default floor for all other services would have to be lowered to maintain budget neutrality.

Bonus payments for services provided in underserved areas: ASIM supports this recommendation.

Reduce Outlier Intensity Procedures: If analysis by HCFA and others demonstrates that outlier intensity procedure RVUs are overvalued based on resource costs, ASIM would support applying the savings to increase the payments for primary care services. An equivalent amount of increase could also be accomplished by a bonus payment or separate adjustment factor for E/M services, as explained below.

Increase the RVUs for office visits to reflect time spent before and after visits: We believe that it is appropriate to reexamine whether the current RVUs undervalue pre and post encounter work, and to selectively increase the RVUs for visits that are undervalued. A decision to raise the pre- and post- encounter RVUs by at least 10 percent seems like a reasonable outcome of such an reexamination. To maintain the credibility of the RBRVS, however, it would be desirable to first ask the Secretary of HHS, in consultation with the PPRC, physician organizations, and the RVS Update Committee (RUC), to reexamine the work RVUs for office visits to determine whether they objectively reflect the current resource costs of providing those service, and if not, to institute improvements. We would expect that such a reexamination would result in a recommendation to

increase the pre- and post encounter RVUs, possibly by more than 10 percent. This would help guard against any concern that the RVUs are being inappropriately manipulated for reasons other than accurately measuring the resource costs of providing physician services.

ASIM would note that several very important categories of primary care services were ignored during the originai RBRVS survey due to the wording of the CPT codes on which the survey was based. The CPT codes focus almost exclusively on the actual encounter between a physician and patient and other services provided only on the day of the patient's visit. Furthermore, the clinical vignettes now used by CPT largely describe patients with single, severe symptoms rather than multiple, chronic symptoms and diseases that typically require substantial follow-up and which form the largest portion of an internal medicine practice. The omission of these primary care services limited the RVUs for office visits to inadequately low levels. These services include prolonged physician services, case management services -- in particular, the low intensity case management of 15 to 30 minutes per month, extensive telephone services and follow-up services to communicate results of lab services and provide counseling based on those results. We believe these are among the issues that should be considered in any reexamination of pre- and post-encounter RVUs undertaken by the Department.

As an alternative to changing the RVUs for visits to accomplish the administration's goals, ASIM has suggested that the administration consider an alternative approach to making improvements in payments for visits and other E/M services, through a separate adjustment factor or bonus payments, that would eliminate the likely objections to changing work RVUs for reasons other than changes in resource costs. This proposal is explained below.

Proposal to Redistribute Office Consultation RVUs to All Office Visits: ASIM does not support this proposal. The credibility of the RBRVS is based upon the belief that it objectively measures the resource costs of physician services. Office consultations do involve more resources than office visits, and should appropriately have a higher work RVU. ASIM does support increasing the payments for office visits by the amount that would be accomplished by this administration proposal, but would fund the increase by lowering payments for all non-E/M services, rather than reducing the payments for office consultations. As explained below, ASIM has developed an approach for increasing payments for office visits and other E/M services that would not necessitate adjustments in the RVUs.

Creation of a separate adjustment factor or bonus payments for primary care: ASIM believes that Congress should change the formula for determining payments under the Medicare fee schedule to create two separate annual adjustment factors for E/M services and for all other services. If this proposal is accepted, payments would be determined by the total RVUs, multiplied by the geographic adjustment factor, multiplied by a single conversion factor for all services updated by the MEI, the product of which would then be multiplied by the separate adjustment factors for E/M services and for all other services.

The separate adjustment factors would be used to increase or decrease the update by the amounts needed to maintain budget neutrality due to refinements or changes in RVUs, to make other policy adjustments that are independent of the RBRVS, and to reflect the amount that actual expenditures compared to the applicable VPSs for each category of services. For E/M services, ASIM proposes that the adjustment factor as set by law could be no less than 1.00. In effect, a floor would be placed on total payments for E/M services so that they would not be lowered due to refinements of the RVUs or application of the VPS. The E/M adjustment factor could be

increased to more than 1.00 in any given year, however, if spending for E/M services fell under the applicable VPS, or because the administration wanted to explicitly recommend a "bonus" for E/M services in order to create incentives for primary care, rather than accomplishing this by changes in the RVUs for E/M services.

The adjustment factor for all other non-evaluation and management services would start out at 1.00, but would then be adjusted upward or downward based on how spending for those services compared to the applicable VPSs, and downward to offset any increased expenditures due to refinements of new or revised CPT codes for any services included in the fee schedule.

What would this accomplish? It would enable the administration and Congress to make an explicit decision to protect E/M services from any reductions due to refinements of RVUs, and to shift overall payments to E/M services by providing them with a higher adjustment factor, without changing the RVUs in a way that could be viewed as violating the concept of basing the work RVUs on resource costs. It would also maintain the integrity of the conversion factor, since all services would have the same conversion factor. In other words, the RVUs multiplied by the single conversion factor would represent the "pure" unadjusted RBRVS fee schedule. The actual fee schedule payments <u>after application of the annual adjustment factor</u> for each category of service would reflect other policy considerations, including the budget neutrality requirements governing refinements of RVUs, providing a bonus or penalty based upon performance compared to the applicable VPSs, and protecting E/M services from reductions. By separating out the "pure" RBRVS from the adjustments being made for other purposes, the results would be far more credible with physicians, and far less prone to misunderstandings by other payers, than changing RVUs for budgetary or other policy reasons.

Short of creating separate adjustment factors for E/M and non-E/M services, as described above, the administration's objective of improving payments for certain primary care visits could be more narrowly accomplished by mandating bonus payments for those services, rather than by adjusting RVUs as has been proposed by the President. This would simply require that payments for office visits and other designated primary care services be increased by adding a bonus that is equal to how much payments would have been increased if the pre- and post-operative RVUs were adjusted, and office consult RVUs were redistributed, as the President's plan proposes. The bonus payments for services in medically underserved areas provides an easily adaptable precedent for increasing payments for selective designated services to accomplish policy objectives, without altering the RVUs for those services. The bonus payments could be funded in a budget neutral manner by lowering the conversion factor for all other non-E/M services, or by mandating that a budget neutrality "deflator" be applied to payments for those other services.

Increasing payments for primary care and other E/M services through a separate adjustment factor in the fee schedule formula, or by mandating bonus payments for designated visit services, would redistribute dollars towards primary care without leading to concerns that the RBRVS is being "distorted". We urge the Congress to consider requiring that the increases be accomplished in this manner. If, however, the choice is between doing nothing to increase payments for primary care, or adjusting the RVUs for pre- and post service work and resource costs as proposed by the administration, then ASIM would support the adjustments in the RVUs.

Other Refinements to the Fee Schedule

In addition to the changes recommended by the administration, and ASIM's suggestions for ways to accomplish those objectives without requiring changes in the RVUs, ASIM believes that it is essential that further improvements be made in the Medicare fee schedule. ASIM urges Congress to make further improvements in the geographic practice cost indices (GPCIs). Physicians continue to be concerned that the GPCIs are based on inaccurate or outdated data. Legislation to mandate that the GPCIs be based on more accurate and timely data was dropped from OBRA '93 due to the Byrd rule. ASIM asks Congress and the administration to move ahead on improving the GPCIs.

Finally, ASIM would like to thank this committee for helping to bring to fruition this year a number of refinements to Medicare which we have advocated for quite some time. Specifically, the restoration of payments for EKG interpretation and repeal of the discount payments to new physicians were welcome reforms and we appreciate the important role played by the committee in bringing about these improvements.

Reduction in the Medicare Hassle Factor

The changes in Medicare procedures proposed by the administration address many of the hassles commonly experienced by internists and their patients in dealing with Medicare. Uniform claims forms and the development of other technologies to facilitate exchange of information can also ease the administrative burden for physicians and patients.

ASIM's 1993 House of Delegates endorsed the ultimate incorporation of Medicare beneficiaries into the broader system of health alliances and accountable health plans. Although the Medicare program should remain separate for a specified period of time in order to avoid severe disruptions to a vulnerable population, consistency will be served by eventually moving all Americans under a uniform health care system.

Expanding Patient Choices Under Medicare

ASIM is also pleased with what appears to be an extension of the point-of-service option provided to all alliance health plans to Medicare managed care plans. Adoption of the point-of-service option has been a key tenet of ASIM's proposals to enhance patient choice of physician. The administration is to be commended for applying this principle to Medicare managed care programs.

Development and Support for Graduate Medical Education

We agree with the goal to increase significantly the number of physicians being trained in primary care. An argument can be made that quick progress on reaching this goal is more important than meeting the specific number by a specified date. Would training 45 percent of physicians in the generalist specialties within a defined period of time necessarily be unacceptable, since this would still be a vast improvement over the current system? In other words, a goal rather than an absolute percentage limit may be more politically acceptable. The National Council on Graduate Medical Education, which the administration's plan would create, could be charged with developing recommendations to reach the target within a defined period of time, but be given some flexibility to make recommendations on the number of residency slots in each specialty that could deviate somewhat from the goal, if it can justify why the goal cannot be fully achieved.

To the maximum extent possible, physicians who are already in the pipeline in a specialty "for which excess supply exists" should be able to complete their training if they so choose. It wouldn't seem fair or desirable to suddenly force them out, when they went into those programs based on certain expectations and commitments that are now being changed after the fact. Some, of course, may decide that the market is changing and decide on their own to refocus their interests on primary care. But for those who do not, ASIM does not think it is desirable to pull the rug out from under them.

We agree with creating a national body to make recommendations on the number of training positions in each specialty. ASIM has previously endorsed Chairman Waxman's bill, which has a similar commission reporting to HHS as would the Health Security Act. Senator Baucus has introduced a bill that would have the commission report directly to Congress for an up-or-down vote, similar to the base closing commission. He argues that this would be much less likely to result in the decision on positions being "politicized" as constituents with a vested interest in the outcome lobby Congress to direct how HHS allocates funding for each position. ASIM sees pros and cons to both approaches, but suggests that Congress consider this alternative. If the Secretary is to determine the number of training positions in each specialty that will be funded, based on the advice of the Council, we think it is critical that the Secretary's proposal be made in the form of a proposed rule for comment, not an interim final regulation.

We are pleased to see that the Council would have to include practicing physician members, as well as other health professionals and educators. ASIM believes that there should be a specific requirement that there be an appointee for each of the generalist specialties (internal medicine, family practice, pediatrics).

There should also be a specific requirement that the Council issue its recommendations in the form of a draft report to the Secretary, with a defined comment period before the report is finalized and submitted to HHS. The widespread anxiety within the profession about this proposal would be greatly alleviated if physicians and educators had assurances that they would have a chance to comment on the recommendations before they are made final.

We agree with requiring all payers to contribute to a pool to fund GME programs. We agree with encouraging the development of programs that emphasize ambulatory training, but recommend that physician offices and Area Health Education Centers (AHECs) be added to the sites in which ambulatory training may occur.

There are two omissions in the President's proposal which do concern ASIM. The first is the lack of any overall cap on the number of residency positions. Chairman Waxman's Primary Care Workforce Act would limit the total number of entry positions to no more than 110 percent of U. S. medical school graduates. Given the link between workforce supply and health system costs, we believe this cap should be part of any graduate medical education reform provision. HR 2804 also outlines criteria that must be considered when slots are allocated to each training program. The medical profession and other interested parties should know the specific criteria on which programs are to be judged and ASIM urges the inclusion of these details as well.

<u>Conclusion</u>

We commend President Clinton for what he has accomplished so far, and reiterate our willingness to work with the administration, Congress, and others to achieve enactment of legislation to bring about comprehensive health system reform. ASIM for its part will do everything it can to reduce the negativism that threatens to undermine the fragile consensus for reform by emphasizing those proposals in the President's plan--as well as in the other proposals in Congress--that we support, and by offering constructive alternatives to those proposals that we do not support, rather than just standing in opposition. ASIM believes that it is time to put an end to "just say no" politics and begin the task of working together to identify the key elements that command substantial support and to iron out our differences on the others.

Mr. WAXMAN. Dr. Hicks.

STATEMENT OF TERRY C. HICKS

Mr. HICKS. Mr. Chairman, and members of the committee, my name is Terry C. Hicks, M.D., and I am a practicing surgeon at the Ochsner Clinic in New Orleans. On behalf of more than 60,000 fellows of the American College of Surgeons, I am pleased to share our views about the President's proposals to help finance health care reform through major reductions in payments for services that are rendered under the Medicare program.

The college recognizes that health reform will undoubtedly require an additional financial commitment to achieve the goal of universal access, but the college believes the administration has an unrealistic expectation about how much of this financial support should come from very deep reductions in current payments for services provided to the elderly and disabled under the Medicare program. We do not see how it is possible to adopt cuts of the magnitude proposed in the draft Health Security Act without potentially undermining the beneficiary and provider confidence in the integrity of the Medicare program.

The magnitude of the Medicare cuts proposed in the President's health care reform is not the college's only concern. While we do not, in general, disagree with the primary care policy raised in the plan, we are disturbed by the attempt to address many of these objectives at the expense of other physician services that the elderly also require.

For example, it can hardly be considered fair for the administration to propose paying surgical services less than justified under Medicare's resource-based payment methodology in order to pay primary care services more than is justified under the same resource system.

The President's Medicare budget reduction plan includes a number of proposals that would directly affect payments for physician services under the Medicare fee schedule, and due to the time constraints, I would like to briefly address three of the administration's proposals which the college finds most disconcerting.

First, we are concerned about the President's plan to establish a cumulative expenditure goal for physician services under the Medicare volume performance system. As you know, the college has been and remains a major supporter of the performance-based expenditure target concepts, and we have been pleased to see that the Medicare volume performance standards for surgical services have been met in each of the last 2 years.

We believe that the present methods for setting the targets and measuring performance have made understanding the incentives under MVPS very clear. We are, however, concerned that a cumulative approach for aiming at these targets, as the President proposes, does not make the potential risks or rewards as clear as they are under the present system.

Our second area of concern is the provision in the President's bill that calls for a 3 percent reduction in the Medicare fee schedule conversion factor for 1995 for all services but primary care. Make no mistake, this is not a 3 percent cut in the growth rate, rather a 3 percent reduction that will be imposed after freezing the 1994

conversion factor applicable to most physician services under the fee schedule, including surgical services.

Moreover, because the conversion factor would not be adjusted before the reductions are made, the proposal completely ignores the performance-based principles used to set the MVPS target for 1993. This provision is hardly in keeping with the President's call in the past for, quote, "shared sacrifice in an effort to address the Medicare budget and spending problems."

The third area of concern is the President's plan to finance health care reform through Medicare cuts that would establish an entirely new control program on limitations of payments for physician services that are furnished in high cost medical staffs. We strongly oppose this plan, which could particularly penalize physicians who serve on medical staffs of those hospitals that today meet the needs of Medicare patients who have extremely complex problems and require the most intensive kind of surgical and physician services.

Finally, Mr. Chairman, as I said at the outset, we oppose the provisions in the President's plan that arbitrarily increase payments under the Medicare system for primary care services by just as arbitrarily reducing payments for all their physician services. As you know, Congress dedicated several years of hard work and spent millions of dollars to design the Medicare fee schedule that fairly compensated a physician for providing care that was based on the work he or she performed.

When the RBRVS fee schedule was completed, Congress overwhelmingly embraced the concept by enacting it into law and providing funding for its implementation. Now the administration proposes a so-called "incentive" for physicians to provide primary care which would be achieved only at the expense of other physicians. This proposal is inconsistent with the goals of RBRVS which you supported and, therefore, should be rejected in its entirety.

Once again, the college appreciates the opportunity to share its views on these issues, and I would be glad to answer any questions that you may have.

Mr. WAXMAN. Thank you very much, Dr. Hicks.

[The prepared statement of Mr. Hicks follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

presented by

Terry C. Hicks, MD, FACS

RE: Medicare and Health Care Reform

November 15, 1993

Mr. Chairman and Members of the Subcommittee, I am Terry C. Hicks, MD, FACS, Associate Chairman of the Department of Colon and Rectal Surgery at the Ochsner Clinic in New Orleans, LA. On behalf of the more than 60,000 Fellows of the American College of Surgeons, I am pleased to share our views about the President's proposals to help finance health care reform through major new reductions in payments for services under the Medicare program.

The College recognizes that health reform will undoubtedly require an additional financial commitment--the scale of which is not yet clear--to achieve the goal of universal access. But, the College believes that the Administration has unrealistic expectations about how much of this financial support should come from very deep reductions in current

payments for services provided to the elderly and disabled under the Medicare program. We do not see how it is possible to adopt cuts of the magnitude proposed in the draft Health Security Act without potentially undermining beneficiary and provider confidence in the integrity of the Medicare program.

In general, Medicare is a program that works. It still assures most older Americans that they can obtain the high quality health care services they need in the communities in which they live from the physicians and hospitals of their choice. Adopting further massive reductions in payments for Medicare services--even before we know the extent of the commitment to, or shape of, a health reform plan that Congress may approve--seems an unwarranted step to take at this time.

The magnitude of the Medicare cuts proposed in the President's health reform plan is not the College's only concern. While we do not, in general, disagree with the primary care policy objectives raised in the plan, we are very disturbed by the apparent attempt to address many of these objectives <u>at the expense</u> of other physician services that the elderly also require. For example, it can hardly be considered fair for the Administration to propose paying surgical services less than justified under Medicare's resource-based payment methodology in order to pay primary care services more than is justified under the same resource-based approach. We thought this subcommittee and Congress had approved the resource-based fee schedule in an effort to establish payment amounts that accurately reflect the work resources involved in providing physicians' services, adjusted by performance-based

volume considerations. However, the President's budget plan for Medicare makes a sham out of this so-called resource-based system.

Similarly, we think it is inequitable, even rather odd, for the President to recommend eliminating the 10 percent payment incentive for the provision of surgical and other most services in urban health professions shortage areas as a way of doubling the payment bonus for primary care services that are provided in rural and urban shortage areas.

The College does not take issue with the interests of policy makers to meet more effectively the primary care needs of all Americans, including Medicare patients. However, some elements of the President's program seek to achieve this goal in ways that are unfair and could potentially pose barriers to assuring the continued availability of all physicians' services, not just primary care services alone.

The President's Medicare budget reduction plan includes a number of proposals that would directly affect payment for physicians' services under the Medicare fee schedule. The first of these would establish cumulative expenditure goals for physicians' services under the Medicare volume performance standard (MVPS) system. If we understand this provision correctly, fee schedule default updates beginning in 1996 and thereafter would be increased or decreased, taking into account changes in actual expenditures due to changes in the volume and intensity of services over a cumulative period of time. A second, but related provision, would prescribe using growth in the gross domestic product, or GDP, as the proxy

for estimating expected changes in the volume and intensity of physicians' services to set MVPS targets.

We are concerned about adopting such major changes in the MVPS system so soon after we have only just begun to develop some actual experience with its effects on spending growth due to volume changes. Constant changes in the design of the MVPS concept can only make it more and more difficult to understand the incentives for which it was adopted. As you know, the College has been and remains a major supporter of performance-based expenditure target concepts, and we have been pleased to see that the Medicare volume performance standards for surgical services have been met in each of the last two years. We believe that the present methods for setting the targets and measuring performance have made understanding of the incentives under the MVPS very clear. We are concerned that a cumulative approach for comparing targets with performance, as the President proposes, does not make the potential risks or rewards as clear as they are under the current system.

The use of the GDP index as the formula proxy to adjust for volume and intensity to set MVPS targets (except for primary care, where preferential treatment is given) means that Medicare would essentially disregard the actual trends in the demand for most physicians' services and the impact of expanded use of new technologies to care for patients covered by the program. Instead, growth in the economy alone will become the standard for determining how much should be spent for physicians' services in tomorrow's Medicare program. If adopted, this provision further underscores a shift in Medicare spending policy

from finding ways to pay for the care our older citizens actually need, to financing their care on the basis of what the economy can afford.

Another provision in the President's bill calls for a 3 percent reduction in the Medicare fee schedule conversion factor in 1995 for all services but primary care. Make no mistake, this is not a 3 percent cut in a rate of growth. Rather, it is a 3 percent reduction that will be imposed after freezing the 1994 conversion factors applicable to most physicians' services under the fee schedule, including surgical services. Moreover, because the conversion factor would not be adjusted before the reductions are made, the proposal completely ignores the performance-based principles used to set the MVPS targets for 1993. This proposal also seems to ask of some physicians what is not being asked of others. We regard this provision as unfair and hardly in keeping with the President's call in the past for "shared sacrifice" in the effort to address Medicare's budget and spending problems.

The President's plan to finance health reform through Medicare cuts would establish an entirely new control program of limitations on payment for physicians' services furnished by high-cost medical staffs. We strongly oppose this plan, which could particularly penalize physicians who serve on the medical staffs of those hospitals that today meet the needs of Medicare patients having especially complex problems that require the most intensive kinds of surgical and other physicians' services. If the Medicare fee schedule is resource-based, and if physicians ought to be paid for the services they provide, then this provision is entirely unjustified and serves no policy objective whatsoever. The plan would also punish physicians

on the staffs of rural hospitals by paying the medical staffs of some institutions no more than an arbitrarily determined amount compared with services provided to Medicare patients in other rural hospitals. It could even encourage physicians to transfer their patients from one hospital to another in order to escape the effects of this unwarranted penalty.

Medicare patients--all patients for that matter--should be entitled to receive the surgical and physician services that are medically indicated and necessary. And, the physicians who provide these services ought to be fairly compensated for providing that care based on the work they perform. This Administration proposal is inconsistent with these goals, and ought to rejected in its entirety.

Finally, Mr. Chairman, as I said at the outset, we oppose those provisions in the President's plan that <u>arbitrarily</u> increase payments under Medicare for primary care services by just as <u>arbitrarily</u> reducing payments for all other physicians' services. Either Medicare pays for physician services on the basis of the work performed, as Congress determined when it adopted physician payment reforms, or it does not. Millions of dollars and several years were spent in designing a fee schedule that was supposed to have achieved this objective. However, our members, when they study the Administration's proposals, are hard-pressed to understand how this exercise has ever served any objective in recent years except that of budget reduction alone. These so-called "incentives" for physicians to provide primary care would be achieved only at the expense of other physicians and ought not, for this reason, be accepted in the form in which you are being asked to consider them.

Once again, the College appreciates the opportunity to share its views on these issues, and I would be pleased to answer any questions you may have.

Mr. WAXMAN. As you all undoubtedly know by now, the House will take up the Penny-Kasich amendment soon, and I would like to have each of you tell us the position taken by your organizations on this proposal in light of both the large Medicare cuts and the deep cuts in discretionary spending.

Dr. Dickey?

Ms. DICKEY. Well, I think since we have not seen the actual language and, as we have experienced recently in the past when it is unwritten, it frequently is still changing. We have had some difficulty taking an absolute yes or no stand.

We do have a handmade policy that supports means testing for Medicare beneficiaries and supports copayments for services. We have concerns, however, in off year changes in funding for, or caps on public health programs, biomedical research, HIV treatment and issues like that, and some concerns about the rapidity with which this amendment could develop without the usual kinds of discussions and opportunities for input.

So, unfortunately, while some of what is in this is consistent with policy, without the language in front of us, we feel we cannot take a definitive yes or no because it may not look the same tomorrow.

Mr. WAXMAN. Dr. Lichtenfeld?

Mr. LICHTENFELD. I have with me a copy of a letter that ASIM has sent, and I believe this letter has been provided to the committee. Basically, bottom line, we oppose the amendment.

We are concerned about the use of these funds specifically towards deficit reduction. As we mentioned, we are concerned about further impacts on the Medicare program and in the event such changes are to be made, these are funds that should be applied towards health care reform.

Mr. WAXMAN. Thank you. Dr. Hicks?

Mr. HICKS. The American College of Surgeons shares the concerns of this panel and the panels that you have heard earlier today that this may have a devastating impact on discretionary health programs, and the severe Medicare cuts would also inhibit potential health reform efforts.

And, also, a third concern could be that if it comes down, as it is now proposed, that the cumulative effect of these Medicare cuts could lead to access problems for patients.

Mr. WAXMAN. Thank you. As I understand from Mr. Vladeck's testimony earlier today, the principle underlying the President's proposals for revising Medicare payments for physician services is to bring the overall growth of these services in line with inflation and growth in the economy.

Now, I take it from your testimony that all of you take exception to that principle. As you may know, we have had testimony from the American Academy of Family Physicians and the American College of Physicians that supports a mix of market forces and explicit caps on increases in health costs, and I believe that the PPRC has taken the position that increases in the cost of physician services should be limited to inflation growth in population and growth in real income, a standard you would find acceptable for limiting the growth in physician service costs.

Do you think it is inappropriate to limit increases in physician costs to growth in the economy, given the very large share of our economy that is devoted to health services? Dr. Dickey?

Ms. DICKEY. The American Medical Association is opposed to the rigid limits but feels that working on a system of predictable spending that takes into account some of the things you have mentioned, the growth in the population covered, the changes in technology, the changes—for example, HIV coming in has created many impacts on budgets. So we have to put into the factors certainly those issues that we know are going to impact the cost of care.

And because those have, up to this time at least, not been easily predictable, we have concerns about trying to figure out some formula that will tell us exactly how much we are going to spend next year, but realize the need for Congress to have some kind of a budget to look at.

So the importance of having a give and take, a negotiated target to aim at and a willingness of both parties or all involved parties to look back at why you did not meet the target rather than a punitive system that says here is the target, if you don't make it, it must be because you were wrong or did something poorly.

So we could support something along those lines as opposed to believing that health care for the Medicare population is going to grow only as the economy grows. That does not take into account, as you heard earlier today, the fact that is the fastest growing population, the population with ever increasing chronic illnesses which our very successes at treating cause increases in the cost of their care and in how long they are going to be using that care.

Mr. LICHTENFELD. Our position would be along the same lines. It is very difficult, if not impossible, to predict what is going to happen in medical care services. And to put a rigid cap on top of the expansion of those services, or physician fees for that matter, whatever component you wish to look at, would deny the real changes that are occurring almost on a daily basis in how we provide our services.

The question that severe choices would have to be made—for example, there may be some services that increase over which we have no control; we may have various services that require immediate attention, immediate demands; we may have other services that may have to be put off; may be more long term. How will we make those choices? How will we account for them today? If you had looked back to 1975 you would not have anticipated the HIV epidemic we have in 1993. Unexplained unanticipated types of events of that nature.

So we would agree with the concept of yes, it is appropriate to establish a target, it is appropriate to review if we do not meet that target why that happened, and to allow that flexibility to be put into any health care reform proposal.

Mr. HICKS. Quickly, bearing in mind their comments. The concept of having new technology, social problems such as drugs and trauma, the greying of America, all of these problems make it difficult to define correctly what the costs are going to be from a year-to-year basis. If you try to graph something out that you have the GDP graph against what we are going to spend on health care, it is not an absolute thing you can do.

I think targets are a necessity, but if Congress is flexible with it, then I think it can work.

Mr. WAXMAN. Let me ask you to comment on the proposal in the President's plan to solicit competitive bids for cataract and cardiac bypass surgeries. As I understand the proposal, hospitals and their physicians would offer a combined price covering both the facility and professional fees for these procedures. Bids would only be solicited in urban areas and beneficiaries would be free to go to any provider for their service. However, if the beneficiary selected a center chosen in the bidding process, they would be eligible for a rebate equal to 10 percent of the program's savings.

This seems to me like a win-win situation for beneficiaries who have access to services provided in urban areas. Dr. Dickey, I believe you testified that the AMA opposes this provision, and, Dr. Lichtenfeld, you and Dr. Hicks do not comment directly on this proposal. I would like to hear further from you about it.

Ms. DICKEY. Let me address a little further our comments about it. This was the section called "centers for excellence," and yet it would appear, as you read the legislation, that we are only talking about excellence in terms of the lowness of the cost as opposed to excellence, which most of our patients may interpret as meaning they are better at doing whatever it is they do.

So I think it needs to be clarified for the purposes of communicating with Medicare beneficiaries what the center of excellence label comes from. Does it come from quality standards; does it come from cost standards or a combination of the two of those?

It wasn't clear to us whether all Medicare beneficiaries would be forced to go. Your comments have clarified some of our concerns. I am in a fairly small town. Many of my patients would prefer to stay locally when the service can be obtained locally, and do not want to be forced to go to a large urban center someplace. So if the beneficiary has the opportunity to choose and can look at the evaluation of quality as well as cost of the service, that would address a large part of our concerns.

As I said earlier, though, another of the issues with competitive bidding is it is terribly important you are getting the same service when you make the bid. If you do not get a service that meets the patient's need, even though the price tag is lower, you may in the long run do more harm than good.

Mr. WAXMAN. Thank you.

Mr. LICHTENFELD. In a general sense, with respect to the concepts you are talking about, ASIM has a general policy in favor of the concept. More importantly, though, and of concern to us is the competitive bidding as it applies to Medicare populations with respect to laboratory services. CT's and MRI's have been suggested in the plan. We do have some reservation with respect to that. And, in fact, we have substantial reservation with respect to that especially as it impacts on laboratory services provided in physician offices and the ability of physicians and patients to get the care that, the information that will provide them with the best care in the most timely fashion.

So if we extend your question beyond that, as I mentioned in my testimony, we have some significant problems with the competitive bidding proposal.

Mr. WAXMAN. Dr. Hicks?

Mr. HICKS. I think in the present health care legislation, the problem I have is the term is thrown out there, "centers of excellence," and it is kind of a misnomer in the sense it does not define what a center of excellence is.

My concerns are more about the details, before the college could make a stand one way or the other. And that would be what kind of quality level are we looking at; how is this going to be determined? Will we have outcome studies? Who will run the studies and what is going to be severity levels? Will we look at those kind of issues?

So, if you look and that data becomes clear, it would be easier to make a statement about it. But I don't think at this time with that limited amount of information you could do so.

Mr. WAXMAN. Thank you very much.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I would like to return to a line of questioning that was engaged in with another group of witnesses. That has to do with balance billing. The President's proposal prohibits balance billing in the Medicare system, and I would like to hear from each of you. Do you think that we need to draw some lines between types of positions on balance billing? If so, where you might draw those lines?

Start with whoever would like to plunge in.

Ms. DICKEY. We seem to start here and move down. The AMA policy is strongly in favor of maintaining balance billing for a number of reasons. I think we see it, as Dr. Ginsburg pointed out earlier today, as somewhat of a safety valve to be sure that an increased number of physicians are willing to continue to take care of Medicare beneficiaries.

Certainly we have seen the number of participating physicians, those people who sign a contract, that say they will accept as payment in full the copay plus Medicare payment. But there is still a significant number of physicians who choose to either take Medicare payment in full on a case-by-case basis or choose to balance bill. And for Medicare patients to lose access to those people, to those physicians or those particular facilities, seems to limit their choice.

Mr. GREENWOOD. If I can interrupt you for a second?

Ms. DICKEY. Oh, sure.

Mr. GREENWOOD. Thank you for reminding me, it was Dr. Ginsburg to whom I had posed these questions before, and he indicated there was a dearth of statistical information or experiential information about what happens, whether it is the Medicare system or the Medicaid system. There is a movement that limits balance billing. Does the AMA have such information?

Ms. DICKEY. Unfortunately, what we have is the same thing Dr. Ginsburg and others have. We have a lot of anecdotal information. Part of the problem is there are so many things happening to change both of these programs virtually simultaneously that it is very difficult to break down which specific thing it is that creates the problem.

As I say, we do have clear evidence across the country. In almost every State, the number of physicians signing participation agree-

ments is increasing every year, I believe since the original agreements came out. That would suggest that the issue of simplification of relations between the physician and Medicare at some point becomes more important than the balance billing does.

But there are still significant numbers of physicians who choose to maintain the right to balance bill, although in surveys, the vast majority, in excess of 90 percent, the physicians forego the balance billing in at least individual cases when patients demonstrate that they have some concerns with being able to pay that balance billing.

Mr. GREENWOOD. Do you know what percentage of physicians forego balance billing entirely?

Ms. DICKEY. The participation rate changes State by State, but I believe we are around 70—I am sorry, 89 percent. It is growing even faster than I can keep up with the numbers. So it is very high.

Mr. GREENWOOD. Then it is fair to say the President's proposals will affect this remaining 11 percent. Sorry for the interruption.

Ms. DICKEY. That is all right. If the significant Medicare cuts do continue, from a policy perspective, we have to continue to ask that balance billing remain.

Part of the other issue may well be that these erode the amount of payment for physicians. You may find additional numbers of physicians who see the balance billing as the difference between the ability to see Medicare patients and the feeling that they cannot afford to bear the cost. A large number of physicians tell us that their Medicaid payment is right at their cost of opening the doors and that there is no profit in it. So balance billing can sometimes make the difference and may be the safety valve if we see ratcheting down of the Medicare payments.

Mr. GREENWOOD. If we know that it is 89 percent, and it sounds like you know a fair amount about this issue statistically, do we know—and I think you whispered the 89 in her ear, so maybe I should——

Ms. DICKEY. This is Janet Horan, Legislative Counsel with AMA.

Mr. GREENWOOD. Thank you. Do we know much about who the 11 percent are? My inclination would be that maybe they are more disproportionately the primary care physician. Is that the case?

Ms. HORAN. I don't have the information with me today but we can get it to you. Our center for research has done, through the SMS survey, has asked physicians this question, and we can break it down by specialty and areas also. I can get it to you.

Mr. GREENWOOD. That would be a big help, and I would like to have that information. I would ask that you do that.

If the Congress decides not to go all the way with a prohibition on balance budgeting, nor allow an across-the-board carte blanche, it could be that by looking at that 11 percent, we could draw a line that constitutes a compromise.

Would either of the other of you care to respond?

Mr. LICHTENFELD. A couple of points I want to make.

First off, there were comments made earlier today that the allowance is 15 percent if you do not balance bill. In reality, it is 9.25 percent. If a doctor who does not participate in the Medicare program takes a 5 percent cut in payments and then is allowed to bill

15 percent above that amount, that translates into a difference actually of 89.25 percent. Point number one.

Point number two, and you mentioned earlier your experience in Pennsylvania, which I am from Maryland and I was active in the legislature—not as a legislator but active in this issue—if you remember, it was not so long ago there were a tremendous number of bills throughout the country for mandated Medicare assignment, some of which passed, many of which failed. You do not hear it any more. You do not hear that push any more.

So, really, in fact, if you look at the natural evolution of the situation as such, the system seems to be working as it presently stands. Providers are doing what they choose to do, which in fact represents—at least in Maryland—a substantial number of participating physicians, and virtually, I would say at this point over 90 percent of the claims are accepted on assignment.

So you have doctors who really are participating in the effort irrespective of whether they are actually participating physicians, quote-unquote, or not.

Mr. LICHTENFELD. The third point I would like to make is that up until this point in time, you asked the question about, well, you know, what happens if we change the law? What data do you have? The reality is that Medicare does not exist in a vacuum and there are indeed other safety valves beyond the issue of the balanced billing just for the Medicare population.

We have heard—we haven't heard much today, but realities about cost shifting, for example. Cost shifting, whether—I am not putting a judgment value on it. I don't necessarily think it is right, but the reality is it occurs. It also allows people like me to do some of the things that I want to do, that is, continue to take care of my Medicare patients, even though I literally suffer a loss of providing that service in my office because I have other means of making up that difference.

Take away some of those differences, and again, I am providing information; I am not providing judgments, but if you look at the issue with regard to that 40 percent difference between current market values and Medicare payments, ratchet that down, then you will know or may have some better idea of what will happen.

So in bottom line, I think physicians have maintained their responsibilities generally to the Medicare parents. The earlier evidence, as we heard testimony from Dr. Ginsburg earlier today, was that there has not been access problems; there is some question from the AARP that maybe there are.

But change the dynamics of the system and there may be some very real impact, and we don't have a—at least to my knowledge sitting here now, a very good model that we can go back and look at to say what the real effects of that kind of change would be.

Mr. HICKS. Just make a brief comment that the college, because of the small numbers of surgeons who are not taking assignment, it is such a small number that it really doesn't affect surgeons as much in the billing. It is also such a small economic issue it is probably worth maintaining.

But I think he brought up an interesting point in the sense that if you really look at—I feel this sense of everybody being pressed about taking care of Medicare patients at a near loss.

I would be more than glad to provide for you a fee schedule to let you see for an EM visit if somebody comes to the office to see you for a general complaint, and compare that to the cost of getting your washer and dryer looked at or something else.

It really is. It is completely out of line and the problem then becomes people say, well, I don't want to see Medicare patients. I can't even open my doors and see them. I only do it for the patients I have strong bonds with and they continue to do that.

Ms. DICKEY. If I may, I, as I said earlier, work in a low income clinic and we take care of Medicaid patients, people who don't have any mechanism to pay, and my director told me yesterday our single largest group of new people signing in are Medicare patients.

Generally that means if they are coming to our clinic, it is because they can't find health care elsewhere. Another anecdote, but something we are keeping a close eye on in our local community.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

I want to thank all of you for your participation. I think you have given us very helpful information for the record. Thank you.

That concludes our business for today. We stand adjourned.

[Whereupon, at 3:55 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

HEALTH CARE REFORM

Impact on Medicaid and Low-Income People

FRIDAY, NOVEMBER 19, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Today, we look at the impact of President Clinton's Health Security Act on Medicaid beneficiaries and other low-income people.

Medicaid is the major source of health care financing for the poor. It covers acute care and long-term care services for about 33 million low-income Americans, about half of whom are children. It has increased access to badly needed health care services for many poor people.

During the 1980's, this subcommittee authored a number of incremental improvements in the Medicaid program. We extended coverage to low-income pregnant women and children who do not receive welfare. We strengthened the preventive services to benefit more poor children and expanded outreach programs to benefit low-income pregnant women. We improved reimbursements for physicians, community health centers and hospitals serving large numbers of Medicaid-eligible women and children. We tried to end what Secretary Reich has called "welfare lock," by making transitional Medicaid coverage available to families who leave welfare and go to work at jobs that did not offer health benefits.

Unfortunately, the more that we tried to improve the program, the more resistance we encountered, not just from the Reagan-Bush administrations, but also in the States because of the financial burdens the changes imposed.

Medicaid is, in effect, a joint venture between the Federal Government and States. The Federal Government has the majority financial interest, funding 57 percent of the program, on average, and in 13 States more than 70 percent of the program's costs. Yet, as you will hear from some of our witnesses today, the States vigorously opposed many of these changes as quote, "unfunded Federal mandates."

So even though Medicaid still covers less than half of the poor in this country, and even though some 3.5 million low-income kids,

one-fourth of all poor children, are still uninsured, incremental Medicaid reform has reached a dead end.

President Clinton's proposal gives us an opportunity for the first time in 12 years to break through this gridlock. He proposes to entitle all Americans, including all low-income Americans, to coverage for comprehensive health services, and he proposes to do so by a date certain: January 1, 1998.

Under the President's plan, the poor would no longer have a stigmatized Medicaid card that many physicians and other providers refuse to accept; instead, they would have the same health security card that all other Americans have and would be offered the same choice of plans as other citizens covered by the regional alliances.

Under the President's plan, the poor would no longer be subject to eligibility standards and benefits limitations that vary dramatically from State to State.

Finally, under the President's plan, the poor would no longer be subject to an assets test in order to qualify for assistance with their premiums and cost sharing. This will dramatically reduce administrative burden and expense, and will enable us to take a major step away from the welfare-based approach to health care financing that has plagued the Medicaid program since its enactment nearly 30 years ago.

These reforms represent a historic and long-overdue departure from the current Medicaid program and its philosophical underpinnings. The benefits to low-income Americans cannot be underestimated. The poor deserve better than emergency room medicine and stigmatized charity care. These structural policy changes are the foundation for something much better.

Unfortunately, their potential is undercut by some serious flaws in the design of the President's plan, starting with a cap on Federal subsidies for low-income families, small businesses and early retirees. We will be asking our witnesses today to help us identify these and other features of the plan that need to be strengthened if health care access for the poor is to be improved.

We will also want to know where the $65 billion in net Federal Medicaid savings that the plan has projected to yield over the next 5 years will go. Are these resources going to be reinvested in improving the health status of low-income Americans? That is a question I think is important to have answered.

Before calling on our first witnesses, I would like to recognize the distinguished ranking minority member of the subcommittee, Mr. Bliley, for any opening remarks he wishes to make.

Mr. BLILEY. Thank you, Mr. Chairman.

Today's hearing examines the effects of the President's health care plan on low-income Americans in the Medicaid program. I hope today that our witnesses can shed some light on the administration's Medicaid proposals which are extremely complex.

First of all, you literally need a road map to even find the various sections of the bill that affect Medicaid and the low income. Second, it is nearly impossible to understand the interactions of the alliance premium structure, the Medicaid program, the cost sharing levels, and the Federal subsidy payments.

Finally, it is difficult to understand the public policy rationale behind some of the administration's proposals. In particular, the ad-

ministration will exacerbate Medicaid cost shifting to the private sector and even has the audacity to write the Medicaid cost shifts into Federal law.

Because of this committee's impact on the Medicaid program, I would like briefly to look at some of the key issues affecting Medicaid. It is no exaggeration to say that the States and counties over the past 7 years have seen the Medicaid program have dramatic effects on their budgets. In some instances they have been unwilling recipients of Federal Medicaid mandates which have singlehandedly done more damage to States' budgets than any other Federal program. Many of these mandates originated from this committee.

In this regard, I would like to remind everyone that former Governor Clinton endorsed both a 1989 National Governors Association resolution, which asked for a moratorium on any new Federal Medicaid mandates, and when Congress ignored that resolution, the 1990 National Governors Association resolution which actually asked for a rollback of Medicaid mandates that were part of OBRA 89.

On the other hand, the States have also participated in some of the most creative accounting and financing schemes of all time. In their innovative use of provider taxes and disproportionate share payments, this is a program they grew in less than 2 years from less than $1 billion to more than $17 billion annually.

Now, I would like to explore this administration's record concerning Medicaid. The administration's first great Medicaid achievement was the approval of the Oregon Medicaid rationing experiment. This experiment in rationing health care only for poor people in Oregon was rejected outright by President Bush. Interestingly, in 1991-1992, the chief Senate opponent of the Oregon rationing experiment was none other than the Senator from Tennessee, Albert Gore. This is what the Vice President said about Oregon's rationing experiment in front of this subcommittee on September 19, 1991.

Quote: "But Oregon has made a tragic choice and a horrible mistake by responding to the plight of the uninsured by developing a scheme that takes from the poor and only the poor; a scheme that preys on the limited political clout and powerlessness of poor women and poor children and whose only answer to skyrocketing health care costs is to ration care." Unquote.

Mr. Gore then ended his statement with this comment: But, of course, under this plan they are now advocating, a child whose mother depends on Medicaid who must have costly medical care or die might be allowed to die. But a child in the very next bed with the same diagnosis and prognosis, whose mother is a State legislator, would be treated.

Seems to me that the Vice President's criticisms are as valid today as they were then, but this rationing experiment is up and running because of this administration.

Now, today, we have another major announcement from the administration that the Vice President's home State of Tennessee has won a waiver allowing the State to cash out their Federal disproportionate share money for the purposes of buying health care for their uninsured. We would like to congratulate the administration on this decision because the major Medicaid provisions of the

Republican health task force bill, H.R. 3080, are patterned on the Tennessee model and we are glad to see the administration embrace our approach.

Subtitle G of H.R. 3080 gives all States the option to embrace the Tennessee approach. That is, all States would be allowed to cash out their Federal and State disproportionate payments in order to buy in additional poor people at below 200 percent of the poverty line, and subtitle H gives States the flexibility to provide managed care without going through the waiver process.

I would like to make one additional comment concerning the Tennessee program. Tennessee is currently receiving more Federal DSH payments than States like New York or California. The reason for this anomaly was that Tennessee was the pioneer in creative accounting and financing schemes that led to the explosion in provider taxes and DSH payments. Other States went to school on Tennessee to see how it was done, but no State ever approached Tennessee's skill at increasing DSH payments, and Tennessee now has a Federal guarantee to reap the benefits of its grossly inflated DSH payments.

I would like to make some comments concerning the administration's funding of the new Medicaid program. Under the Clinton plan, regional alliances will receive from the State and Federal Government payments which will amount to only 95 percent of what would have been paid out if these cash-eligible beneficiaries were still on Medicaid.

Second, the Clinton plan places a stringent CFO and cap on Medicaid payments for these beneficiaries. The cap will cut spending for these beneficiaries by over $22 billion over 5 years.

Third, the Clinton plan cuts Medicaid disproportionate share payments to public hospitals by $55.5 billion.

Finally, the administration caps the low-income premium and cost share subsidies. Clearly, the alliances are going to have to make up the differences through assessments on health plans or higher premiums.

In fact, these three provisions must lead to Medicaid's traditional financial magic trick, cost shifting to the private sector, to make up the Medicaid shortfall. Additionally, the President's plan requires that States maintain their current level of spending for Medicaid in other State programs. The State maintenance of efforts requirement triggers a host of complicated issues.

While some States have taken advantage of optional Medicaid eligibility categories, other States have not. Also, some States have relatively rich Medicaid benefit packages. Consequently, States that have had more generous Medicaid programs will have to maintain much higher levels of State payments than others. The administration's plan will freeze these differences into place. Clearly, this issue must be examined closely.

Finally, the administration's plan will have monumental distribution effects on States. Distribution of subsidies will vary greatly by the number of uninsured in the State and number of low-wage workers.

To conclude, I would like to address our witnesses who are advocates for the poor. It seems that during this administration you have lost your voices. If a Republican administration had approved

the Oregon rationing experiment, the Tennessee waiver, cut $68 billion from the Medicaid program in reconciliation and put on the table a health reform proposal that slashed the Medicaid program by $72 billion and placed Medicaid recipients in an untried system, the Secretary and HCFA Administrator would have been run out of the country by your groups. Maybe today we will finally hear your voices.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Wyden.

Mr. WYDEN. Mr. Chairman, thank you. I am almost speechless, but I do feel compelled to make a short statement at this point since Oregon was invoked.

First, Mr. Chairman, let me say, having sat next to you for 12 years, the fact of the matter is, Mr. Chairman, that millions and millions of poor people in this country have access to health care because year in and year out through the 1980's you took every opportunity to fight for their rights. It seems to me that poor people and their families across this country owe you a great debt of gratitude, because many of them are receiving health care because of the extraordinary work that you have done throughout the 1980's.

I think it also has to be noted, and your statement really acknowledges it, Mr. Chairman, is that the Medicaid system today is in fact busted, it is broken, it does not work for millions and millions of poor people across the country. Medicaid is a Federal-State partnership, and the partnership is out of whack.

I think it is important to address the comments of the gentleman from Virginia, just so the record is straight, Oregon is not rationing health care because you cannot ration health care from people who get none. It is simply impossible. The people in Oregon today who get nothing will get access to a substantial package of benefits tomorrow, and that is being done without taking away any of the essential services that those now on Medicaid receive. That, in my view, is not rationing health care, it is expanding access to health care. And what is so ironic, is George Bush, who said for so long that he was in favor of innovation in Medicaid, when it really required some guts and some courage, George Bush said, the program in Oregon would violate the disabilities law and then he could not offer any proof whatever, no legal documentation to show that was the case.

So I think it is important to set the record straight. And just so that no one is confused at all with respect to the nature of this program, the Governor of Oregon has testified before this subcommittee that the Oregon health plan offers a benefit package that could apply to her and her family just as well as it could apply to the poor people of our country.

Finally, let me close, Mr. Chairman, by saying that I share your view that the Clinton plan provides a fresh opportunity to start over in terms of addressing the health needs of the poor, and now we have a chance, instead of constantly trying to patch up the current Medicaid program that is a jerry-built structure that has been so exasperating to the poor of this country and does not work for them, we have a chance to do the job right from the ground up.

Personally, I want to make sure that States like Oregon are rewarded for their courage and their willingness to get out in front and fight for the rights of the poor, and I look forward to working with you, Mr. Chairman, as we have for more than a decade on these important matters.

Mr. WAXMAN. Thank you, Mr. Wyden. Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. I thought when the gentleman from Oregon said he was at a loss for words he was going to yield back his time. No such chance.

Just to reemphasize what Mr. Bliley said, not only is the Tennessee approach written into the Republican health care reform alternative, the Washington Post today said it was consistent with the President's health care proposal. That may be true, it is also consistent with the Republican health care proposal. It is also consistent with what was in the Republican budget alternative last year, which was rejected out of hand by the Democratic administration. I think it is a good approach and I hope we can find a way to make it work.

I don't disagree with a lot that the chairman said in terms of some of the things that need to be done with Medicaid. I think particularly the idea that it would be folded into the total health care system out there is very constructive, and if those benefits are consistent with what is defined as a standard benefits package, then I think that is good too and that should be a part of any proposal. We disagree, however, on how you get there.

The gentleman from Oregon said correctly that Medicaid is bankrupt and it has consistently been underfunded or unfunded ever since I have been in Congress, which is 8 years. It is running out of control. It is an entitlement program that Congress does not address year in and year out in terms of appropriating funds to cover the costs, and that is right at the heart of the Federal Government's budget deficit problem.

What we are doing here in the proposal, as best I can read it to this point, is taking all funds that go for benefit reimbursement and for disproportionate share payments, which are an extraordinarily high portion of Medicaid payout, and vary disproportionate share in terms of their distribution geographically and flowing them, I am not quite sure how and in what proportions, into the new system.

I don't disagree with the fact all those funds are going to have to be funded into that new system, and I would put a figure of about $65 billion a year on that. If that is not correct, I hope the accurate figure will be revealed to us today. But what is unknown is what raising the level of those benefits to the standard basic benefit package, which we might say is a per capita cost of $1,800, which I think is the administration proposal, then adding to that the broadening of the group up to 150 percent of the level of poverty. I don't necessarily disagree with the approach, but we need to define who that includes, because that is a very unknown quantity, at least as far as this member is concerned in terms of what assumptions have gone into the administration's plan. I hope we can shed some light on that today.

I would thank again our witnesses for being here and look forward to casting some light in these dark corners. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. McMillan. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman. I am pleased that we can have these discussions, Mr. Chairman, and I thank you for holding these hearings on health care reform and particularly as we integrate the Medicaid system in this country into national health care reform.

I am particularly concerned that there are some who would become strident activists for the status quo; who would minimize the impact on our national economy of not reforming our health care system; who would speak out and say that two and three times the inflation rate increases in health care are acceptable; who would endorse a 40 percent higher allocation of our national resources than any other country in the world is acceptable; those who would endorse the inefficiencies of our health care system with its waste, fraud and abuse—that being acceptable. That is not acceptable.

We need to make changes, we need to guarantee to the American people that they can have health care coverage when they need it, when they lose their job; that their kids come out from underneath their policy coverage if there is a divorce in the family, if there is change in their employment situation. We need to put health care on a budget.

For some people, the concept of actually doing something like that is onerous. That means potentially subjecting too many of our citizens, in increasing numbers, to our Medicaid system as it is presently constituted. That is why it is critical, Mr. Chairman, that we incorporate it into national health care reform so that all Americans can have the guarantee that if they need health insurance tomorrow it will be there for them.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler. Mr. Moorhead.

Mr. MOORHEAD. Thank you, Mr. Chairman. I want to join you in welcoming our witnesses today. I especially want to extend a warm welcome to Irene Riley, who is representing the Department of Health Services for the county of Los Angeles.

In her testimony she will address several issues of critical importance to Los Angeles County, such as essential community providers, disproportionate share payments, and undocumented immigrants. The current problems of the health care system are dramatically illustrated by the situation in Los Angeles County. The health budget is over $2 billion, and this is stretched to its limits. It has the highest uninsured population in the country. It has a tremendous number of illegal aliens. The cost of treating illegal aliens is approximately $159 million a year.

Maybe she is going to tell us it is higher. Probably is. Under the President's plan, illegal aliens will not be entitled to a health security card, and I agree that entitling undocumented aliens to the guaranteed benefit package would only provide a greater incentive for individuals to enter this country illegally. However, areas such as Los Angeles will still be required to treat these individuals in emergency situations and will need greater financial assistance than they are currently provided.

I look forward to the testimony of our witnesses, and I want to thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Moorhead. Mr. Brown.

Mr. BROWN. Thank you, very much. I can't count the number of times that I have heard from people that work at human services in counties in my district and from people that are receiving AFDC that the number of times that they have either talked to their clients or the clients themselves, the people themselves, who have time after time seen an opportunity to take a $5 or $6-an-hour job or a $4.50-an-hour job and turn it down because they have an asthmatic or a diabetic child and, pretty clearly, one of the most serious problems of our health care program and welfare program system is the disincentive built into the system to, in a sense, because of health care, keep people on AFDC so that they cannot, they simply cannot afford to lose their health care coverage. And I note the President's plan deals with that. I hope these hearings today will help us begin to move in that direction. Thank you.

Mr. WAXMAN. Thank you, Mr. Brown. Mr. Greenwood.

Mr. GREENWOOD. No statement, Mr. Chairman.

Mr. WAXMAN. Once again, we are pleased to welcome back to the subcommittee Bruce Vladeck, who is the Administrator of the Health Care Financing Administration and is responsible for managing not only the $156 billion Medicare program for the elderly and disabled, but the $92 billion Medicaid program for the poor.

Diane Rowland was listed first, because we did not think Mr. Vladeck would get here in time, but we are pleased he has arrived in time not only to be first but to hear all of our opening statements as well.

Mr. Vladeck, we are looking forward to your testimony. Without objection, it will be in the record in full, and we would like to ask you to proceed. We are pleased to have you back with us.

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you, Mr. Chairman. Good morning. Good morning, Mr. Bliley, members of the committee. It is a pleasure to be back. It feels like just yesterday when last I met with you, but I must say that the kinds of discussions and questions from all the members of the subcommittee have been extremely helpful and informative to us and I really appreciated the spirit and substance of the discussions and I look forward to more today and in the future.

It is with particular pleasure, Mr. Chairman, to be here today, because I am so cognizant of the extraordinary role you personally have played as chairman of this subcommittee and as a member in improving the Medicaid system over the last decade. To echo something Mr. Wyden said, there are literally millions of Americans and millions of American households who have received needed high quality medical care in large part because of your personal involvement and commitment and role, and it is a pleasure to be able to acknowledge that as we start off talking about the future of the Medicaid program this morning.

It is also a particular pleasure to be accompanied today by Sally Richardson, recently appointed as the Director of the Medicaid Bu-

reau at the Health Care Financing Administration, and a public administrator of extraordinary talent and experience, especially in State government, whose presence symbolizes our continuing commitment to the most effective management and policy innovation in the Medicaid program.

Today, our subject is what health care reform means for low-income citizens and the changing world of States in administering health care for this population, and the savings we will achieve by integrating Medicaid into the mainstream of the health care system.

For nearly three decades, as you know, the Federal Government and States have provided medical assistance through the Medicaid program covering today more than 32 million Americans. Under the President's proposal, all Americans, young and old, poor and nonpoor, working and retired, will be ensured the security of basic health care coverage. Our current system bases eligibility for health care on income, resource and categorical criteria, leaving millions without basic benefits. Under the President's plan, no American will be excluded from basic health care benefits.

The President's Health Security Act proposes universal coverage through the shared contributions of individuals, States, alliances, the Federal Government, and employers. Individuals will be able to select the coverage that best serves their needs. Choice will extend to everyone, from the most destitute to the most economically advantaged.

Medicaid, the program which has traditionally served many of our needy citizens, will be largely absorbed into the mainstream of the Nation's health care system. Health care coverage will no longer favor individuals on the basis of income, age or sex by somehow defining them as needier than others. Health care coverage will not exclude young healthy males because they do not have children, or married couples because the primary wage earner has a minimum wage job.

Furthermore, under the Health Security Act no provider will be reimbursed for acute care services at a different level of payment just because the patient is covered by Medicaid. Providers will be blind to an individual's income and coverage status.

The Health Security Act will establish a system whose time is long overdue. This administration intends to replace fragmented coverage and services with uniform coverage and comprehensive benefits without regard to medical condition, status, or ability to pay.

We are going to achieve this goal through a number of mechanisms designed to maximize the best aspects of private insurance and of publicly funded programs to produce a system that is simple, efficient, secure, cost effective, quality driven, and choice oriented.

Under the Health Security Act, States will continue their shared partnership in the Medicaid program but will benefit from redirected Federal funding and from savings from a new relationship with the private sector through the alliance health plans. The Health Security Act will integrate Medicaid acute services into alliance plans. The most vulnerable poor will receive full coverage while maintaining their ability to choose among the plans.

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Low-income individuals receiving cash assistance may choose any alliance plan with premiums at or below the weighted average premium for all plans in their alliance without paying any premium at all. If they choose a plan with a premium above this average, they will be responsible for the additional cost.

The State and Federal Governments will pay a premium to the alliance for Medicaid individuals receiving cash assistance based on 95 percent of current State per capita Medicaid spending on those covered services trended forward by national growth rates. Other low-income individuals who do not receive cash assistance will also receive health care coverage through alliance plans. These individuals will make a premium contribution based on a sliding scale related to income. Employers of low-income employees must pay premiums to the alliance based on private sector rates, as they do for all employees.

States will continue to support the provision of health care to low-income individuals who participate in Medicaid but who do not qualify for cash assistance. States will make "maintenance of effort" payments to the alliances based on 1993 spending for Medicaid services that will be covered by the alliance health plans. Maintenance of effort payments will be used to help finance the costs of Federal discounts to individuals with incomes below 150 percent of poverty.

Cost sharing for low-income individuals will be subsidized. If a low cost sharing plan, such as an HMO, is not available, then cost sharing for individuals receiving cash assistance will be reduced to 20 percent of the HMO cost sharing schedule, or $2 per visit. Additionally, the Health Security Act will create a new Federal program that will provide uniform supplemental benefits to low-income children. This will ensure that most children who would have been eligible for Medicaid will continue to have access to services such as transportation to health care providers, hearing aids, outpatient therapies and other medically necessary services not covered under the comprehensive benefit package or under the Medicaid long-term care benefit.

States may also continue to provide optional Medicaid services to adult recipients of cash assistance as under current law. States will continue to pay for elderly Medicare beneficiaries who qualify to have their out-of-pocket expenses paid by Medicaid. A new vulnerable population adjustment program will provide additional Federal payments to hospitals. Hospitals will qualify for these payments if at least 25 percent of their patients are of low income. The adjustment will include payments for hospitals in States with large numbers of undocumented persons.

Annual funding for the vulnerable population adjustment will be $1 billion a year once the alliances are fully implemented. In addition to mainstreaming current Medicaid recipients into alliance health plans, the Health Security Act will make other improvements to the Medicaid program. Medicaid long-term care benefits will continue for eligible patients in nursing facilities, intermediate care facilities for the mentally retarded, and community-based long-term care regardless of whether or not they receive cash assistance. These benefits will be improved in several ways.

The monthly personal needs allowance permitted for institutionalized Medicaid patients will be increased. Further, States may opt to increase the asset standard for institutional long-term care eligibility from the current $2,000 limit to $12,000. At the same time, the Health Security Act will produce net Medicaid savings totalling approximately $65 billion. Those savings will result from discontinuing payments to hospitals serving a disproportionate share of low-income individuals as States enter the alliance system.

These payments were established to help hospitals with large, uncompensated care burdens. Since universal coverage will virtually eliminate this problem, disproportionate share hospital payments will be discontinued. The vulnerable population adjustment program will help those hospitals continuing to require some assistance. Medicaid savings will also result from lowering payments to alliances based on 1993 Medicaid spending adjusted to reflect only health care inflation and population growth. Under a complete reform of the health care system, plans will be able to provide better coverage for less cost and increases in spending, therefore, will be substantially lower than Medicaid growth rates as projected under the current system. We will reduce State Medicaid administrative responsibilities in terms of enrollment, oversight, rate setting, and claims processing by including Medicaid recipients in the alliances and providing supplemental services to children through a separate program, and we will replace some of Medicaid's spending for prescription drugs for low-income elderly with the new Medicare drug benefit.

Medicaid will cover premiums and cost sharing for low-income Medicare beneficiaries for the drug benefit as for other Medicare benefits.

Mr. Chairman, Mr. Bliley, a new era in the way we provide basic health care services to our underserved and low income is about to be realized. What the President envisions is a system that not only includes every individual in this Nation but a system that also provides quality care at an affordable price. We have designed a program that combines the best of what America has to give—private sector innovation with public sector initiative.

I look forward to working with you and this committee as we proceed in the coming months to forge a plan that not only will benefit this generation but future generations of Americans as well. Together we can accomplish what has aluded us for so long, basic comprehensive health care for all. I thank you very much.

Mr. WAXMAN. Mr. Vladeck, thank you very much for your testimony.

[The prepared statement of Mr. Vladeck follows:]

STATEMENT OF

BRUCE C. VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman, Members of the Subcommittee, I am pleased to have yet another opportunity to continue our discussions of the President's proposed Health Security Act. Today, I will explain what health care reform means for our low income citizens, the changing role of States in administering health care for this population, and how we will achieve savings by integrating Medicaid into the mainstream of our health care system.

For nearly three decades, the Federal government and States have provided medical assistance through the Medicaid program. Today, more than 32 million Americans benefit from Medicaid. In recent years, Congress has expanded Medicaid to include individuals beyond traditionally defined eligibility groups. States, too, have initiated improved coverage and care by serving greater numbers of "medically needy" individuals and by implementing effective managed care programs for certain targeted underserved populations.

Now, with the President's comprehensive health care reform plan, all Americans, young and old, poor, working and retired will be ensured the security of basic health care coverage. The current system bases eligibility for health care on income, resource, and categorical criteria, leaving millions without basic health care benefits. Under the President's plan, no American will be excluded from basic health care benefits.

HEALTH CARE REFORM AND LOW INCOME CITIZENS

The President's Health Security Act proposes universal coverage through the shared contributions of individuals, States, alliances, the Federal government and employers.

Individuals will be able to select the coverage that best serves their needs. Choice will extend to everyone, from the most destitute to the most economically advantaged individuals.

Medicaid, the program which has traditionally served many of our neediest citizens, will be largely absorbed into the mainstream of our Nation's health care system. Health care coverage will no longer favor certain individuals whose income, age or sex makes them needier than other individuals. Health care coverage will not exclude young, healthy males because they do not have children, or married couples because the primary wage earner has a minimum wage job.

Furthermore, under the Health Security Act, no provider will be reimbursed for acute care services at a lower rate of payment just because a patient is covered by Medicaid. Providers will be blind to an individual's status as a Medicaid recipient.

The Health Security Act will establish a system whose time is long overdue. This Administration intends to replace fragmented coverage and services with uniform coverage and comprehensive benefits, without regard for medical condition or ability

to pay.

We are going to achieve this goal through a number of mechanisms designed to maximize the best aspects of private insurance and publicly funded programs. This effort will produce a system that is simple, efficient, secure, cost effective, quality driven, and choice oriented.

THE CHANGING ROLE OF THE MEDICAID PROGRAM

The Medicaid program is a jointly funded Federal/State program administered within broad Federal guidelines by the States. States currently receive Federal matching payments based upon a State's ability to share in program costs as measured by per capita income.

Under the Health Security Act, States will continue their shared Federal partnership in the Medicaid program, but will benefit from redirected Federal funding and savings from a new relationship with the private sector through alliance health plans.

Recipients will benefit from participation in an integrated health care system that leaves no one without coverage and assures that everyone's coverage will be the same throughout the country. And, providers of acute care services will benefit from more uniformly applied payment rates that treat all patients equally.

Coverage In Alliance Plans

The Health Security Act will integrate Medicaid acute care services into alliance plans. The most vulnerable poor will receive full coverage while maintaining the ability to choose among health plans. Low-income individuals receiving cash assistance may choose any alliance plan with premiums at or below the weighted average premium for all plans in their alliance, without paying a premium. If they choose a plan with premiums above this average, they will be responsible for the additional cost.

The State and the Federal government will pay a premium to the alliance for Medicaid individuals receiving cash assistance based on 95 percent of current State per capita Medicaid spending on alliance-covered services, trended forward by national growth rates.

Other low-income individuals who do not receive cash assistance will also receive health care coverage through alliance health plans. These individuals will make a premium contribution based on a sliding scale related to income. Employers of low-income employees will pay premiums to the alliance based on private sector rates, as they do for all employees.

<u>State Maintenance of Effort</u>

States will continue to support the provision of health care to those low-income individuals who participate in Medicaid but do not qualify for cash assistance by making "maintenance of effort" payments to the alliance, based on 1993 spending for Medicaid services that will be covered by alliance health plans. Maintenance of effort payments will be used to help finance the costs of Federal discounts to individuals with incomes below 150 percent of the federal poverty level.

<u>Cost Sharing</u>

Cost-sharing for low income individuals will be subsidized if a low cost-sharing plan, such as an HMO, is not available. And, cost-sharing for individuals receiving cash assistance will be reduced to 20 percent of the HMO cost sharing schedule, or $2 per office visit.

<u>Supplemental Services</u>

Additionally, the Health Security Act will create a new Federal program that will provide uniform supplemental benefits to low-income children. This will ensure that most children who would have been eligible for Medicaid will continue to have access to services such as transportation to health care providers, hearing aids, outpatient therapies and other medically necessary services not covered under the alliance's comprehensive benefit package or under the Medicaid long term care benefit.

States may also continue to provide optional Medicaid services to adult recipients of cash assistance, as under current law. States <u>will</u> continue to pay for elderly Medicare beneficiaries who qualify to have their out-of-pocket expenses paid by Medicaid.

<u>Serving Vulnerable Populations</u>

A portion of State payments intended for hospitals serving a disproportionate share of low income patients will be counted toward State maintenance of effort payments for Federal matching purposes. States will not have to continue disproportionate share hospital payments associated with cash assistance recipients, and these payments are not built into the premium payment to the alliances.

A new Vulnerable Population Adjustment program will provide Federal payment adjustments to hospitals. Hospitals will qualify for these payments if at least 25 percent of their patients have low incomes. The adjustment will include payments for hospitals in States with large numbers of undocumented persons. Annual funding for the Vulnerable Population Adjustment program will be $1 billion once the alliances are fully implemented.

Long-Term Care Benefit

In addition to mainstreaming current Medicaid recipients into alliance health plans, the Health Security Act will make other improvements to the Medicaid program.

Medicaid long-term care benefits will continue for eligible patients in nursing facilities, intermediate care facilities for the mentally retarded and community-based long-term care, regardless of whether they receive cash assistance. These benefits will be improved in several ways. The monthly allowance permitted for institutionalized Medicaid patients to meet personal needs will be increased. Further, States may opt to increase the asset standard for institutional long-term care eligibility from the current $2,000 limit to $12,000.

MEDICAID SAVINGS

The Health Security Act will produce net Medicaid savings totaling approximately $65 billion .

Medicaid savings will result from:

- Discontinuing Medicaid payments to hospitals serving a disproportionate share of low-income individuals as States enter the alliance system. These payments were established to help hospitals with large uncompensated care burdens. Since universal coverage will virtually eliminate this problem, disproportionate share hospital payments would be discontinued. The Vulnerable Population Adjustment program will help those hospitals that continue to require some assistance.

- Lower payments to alliances based on 1993 Medicaid spending, adjusted to reflect health care inflation and population growth. Under a complete reform of the health care system, plans will be able to provide better coverage for less cost, and increases in spending will, therefore, be substantially lower than Medicaid growth rates expected under the current system.

- Reducing State Medicaid administrative responsibilities in enrollment, oversight, rate-setting, and claims processing by including Medicaid recipients in the alliance and by providing supplemental services to children through a separate program.

- Replacing some Medicaid spending for prescription drugs for the low-income elderly with the new Medicare drug benefit. Medicaid will cover premiums and cost sharing for low-income Medicare beneficiaries for this benefit.

CONCLUSION

Mr. Chairman, a new era in the way we provide basic health care services to our underserved and low-income citizens is about to be realized. What the President envisions is a system that not only includes every individual in this nation, but a system that also provides quality care at an affordable price.

We have designed a program that combines the best of what America has to give -- private sector innovation with public sector initiative.

I look forward to working with you and this Committee as we proceed in the coming months to forge a plan that not only will benefit this generation but future generations of Americans as well. Together, we can accomplish what has eluded all of us for so long -- uniform, basic health care for all.

Mr. WAXMAN. Let me start off the questions.

Yesterday, the Secretary announced her approval of Tennessee's application of waivers for a 5-year Medicaid demonstration under section 1115 of the Social Security Act. Under this waiver, the State will enroll up to 1.5 million Medicaid beneficiaries, uninsured and uninsurables into managed care plans that may serve only the poor. This is the fourth section 1115 waiver, health care reform type waiver, that the Secretary has granted this year. The others have gone to Oregon, Hawaii, and Rhode Island.

Under the President's plan, all Americans would be entitled to a comprehensive benefits by January 1, 1998, while States would have the latitude to use managed competition, single payor or other approaches, they would not be allowed to demonstrate only with their poor and uninsured by forcing them to enroll in managed care plans that serve only the poor.

My question is what will happen to the Tennessee, Oregon, Rhode Island, Hawaii, and Arizona Medicaid waivers under the President's plan? Will those States be required to come into the national program or will they be able to continue their managed care demonstrations?

Mr. VLADECK. Mr. Chairman, we have put in an explicit condition on the most recent waivers, including Rhode Island and Tennessee, and I believe Oregon as well, that within a reasonable period of time after the enactment of health care reform, the State will need to conform its system to that which is consistent with the final enacted version of the Health Security Act.

So our anticipation is that each of these States will have to make changes to greater or lesser degrees in order to come into compliance with the Health Security Act once its effective date occurs.

Mr. WAXMAN. Thank you. You testified that the President's plan will produce net Medicaid savings to the Federal Government of $65 billion over 5 years. These savings will come from two sources: Ending Medicaid payment adjustments and disproportionate share hospitals, that is $51 billion; and limiting the annual rate of increase in capitation payments to regional alliances for cash assistance recipients, $22.3 billion.

Where will these Federal savings go? Are they reinvested in improving health care delivery capacity to underserved areas or are they to be applied to reducing the deficit by $58 billion over 5 years?

Mr. VLADECK. Mr. Chairman, if I may, this is sort of a variation on the discussion we had yesterday, and I think it is fair to say that the President's proposal, as outlined, does not seek to earmark particular savings or other particular revenue sources associated with the plan.

The Medicaid savings, along with the Medicare savings, along with the new tax revenues, are all sources of financing for expanded outlays under the plan, the great bulk of which go for providing subsidies and discounts for low-income people and for small employers. But there is not a specific earmarking of any of those input dollars, as it were, for particular output purposes.

Mr. WAXMAN. One of the features that troubles me about the design of the President's bill is the way it treats poor people who are eligible for cash assistance, women and children receiving AFDC,

and elderly and disabled receiving SSI, differently from equally poor people who are not eligible for welfare.

Under the plan, Medicaid will make capitation payments to regional alliances on behalf of cash assistance recipients. But for low-income people who are not receiving AFDC or SSI, the Federal Government will have capped subsidy payments to the alliances, supplemented by State maintenance of effort payments.

What is the logic of this distinction and why make capitation payments at one level for cash assistance recipients and have subsidy payments at another level for those who do not receive cash welfare but are equally poor?

Mr. VLADECK. Mr. Chairman, as you probably know better than anyone, the patterns of eligibility for Medicaid vary dramatically from one State to another. The cash assistance recipients are eligible in every State in the Nation. For the noncash, low-income persons, the eligibility standards vary enormously from one part of the country to another.

In trying to establish a uniform national policy, the obvious dividing line that makes sense equally in States that have been traditionally generous in benefits and States that have been traditionally parsimonious in benefits, is to treat those who had been mandatory eligibles in one way and those who had been eligible at State option in another way in order to have a consistent national policy.

Mr. WAXMAN. Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Chairman, I ask unanimous consent to distribute a chart.

Mr. WAXMAN. Without objection.

[The chart referred to follows:]

Medicaid Cash Eligibles

Interaction between Premiums and Cost-sharing

Blue Cross/ Blue Shield Standard Option	GEHA	MDIPA
Total Family Premium $4,891*	Total Family Premium $5,018*	Total Family Premium $5,500*

Average weighted premium (assuming equal number of recipients in each plan) = $5,136

If Medicaid cash assistance recipients choose MDIPA, they pay $364—the full cost of the amount by which the premium exceeds the average.

Implications

1. Medicaid recipients lose freedom to choose plans because they cannot afford additional premiums in choosing low cost-sharing plans.

2. Federal subsidy payments would be made to the alliances to buy down cost-sharing to the level of the managed care plan.

3. A further reduction in cost-sharing would be required of the health care plan. Plans have to subsidize 80% of the cost-sharing. This could result in plan shortfalls or unwillingness to accept cash assistance enrollees.

Mr. BLILEY. Mr. Vladeck, we looked at a very similar chart yesterday when discussing Medicare. Unfortunately, the same problems exist with the Medicaid program under the President's plan. Under the President's plan, Medicaid beneficiaries are bought into an alliance. The Medicaid program as we currently know it will no longer exist. However, all of the funds flowing into the alliance are capped.

The first is that Medicaid payments for cash eligibles are capped. When fully phased in, these payments will be capped at the CPI. This cap will result in a savings of $22.3 billion over 5 years. Second, State Medicaid payments on behalf of cash eligibles are capped at 95 percent of what they would have been paid out if recipients were still on Medicaid.

Under the Clinton plan, individuals who receive cash assistance will also receive subsidies to pay for premiums, however, these subsidies are also capped. The subsidies made by the Federal Government to the alliances on behalf of poor people for cost sharing are capped at $276 billion over 5 years.

And finally, the President's plan proposes to Medicaid cash eligible would pay only one-fifth of the cost sharing requirements. For example, instead of having to pay $10 for a doctor visit, Medicaid beneficiaries would pay $2 per visit. The health plan would be responsible for the other $8 or 80 percent of the cost sharing requirement.

Under the President's plan, Medicaid beneficiaries would be entitled to the same guaranteed benefits package as everyone else, but the alliance, and in turn the health plans are receiving significantly less money to provide this same level of cap.

Mr. Vladeck, does this not in effect legislate the current cost shifting associated with the Medicaid program? As a consequence of the alliance and the plan's being paid an insufficient amount, won't this either force everyone else's premiums higher or result in plan insolvencies?

Mr. VLADECK. Well, sir, I am not sure I would agree with the proposition that the plans are being paid an insufficient amount. They will be paid for the cash assistance folks at 95 percent of the current Medicaid cost for a system that we know is inefficient; that we know is overly dependent on emergency rooms and other expensive sources of intervention that tend to be relied upon by low-income people in communities without adequate care networks.

We routinely enter into managed care contracts with Medicaid on behalf of Medicaid recipients at 95 percent, or less, of the average fee-for-service cost, and have no shortage of very well-qualified providers willing to enter into such contracts. So I am not sure I would agree with the proposition that the 95 percent of the current level is an inadequate payment level.

If you are moving people into an organized, well-defined, well-organized system of care, our experience would suggest that is a more than adequate basic payment rate.

Mr. BLILEY. Well, I hear what you are saying. When the Secretary of HHS was here and I asked her a similar question, she told me, well, we estimate there is $200 billion worth of waste in the system. I asked her to demonstrate it and the best she could come up with at that time was about $1.5 million.

So I hope that what you are saying is right if this plan is adopted. Because if it is not, we are going to have a very serious shortfall in the alliance, and you either have to go one way or the other: Up the premium or you are going to have insolvency. You are not going to be able to have all these caps and provide all the services unless the money is there.

So I hope it works out. I thank you for your response to my question.

Mr. VLADECK. Thank you.

Mr. WYDEN [presiding]. The time of the gentleman from Virginia has expired.

Mr. Vladeck, I am concerned about how noncash assistance recipients are going to fare under all this. It seems to me they get less help on the premium side and they also seem to get less help on the cash assistance side—excuse me, on the cost sharing side, and these folks are really some of the most vulnerable people in America, pregnant women and kids, the people that this subcommittee has really gone after and tried to help over the last decade. They are going to have substantial cost sharing under the act, including a $400 deductible in the fee-for-service plans.

Now, is this what the administration intends, and if so, what else might be done to try to give some measure of relief to these folks who, I think, are particularly vulnerable and I think the administration wishes to help but in the noncash assistance area, I think it is going to hurt some folks.

Mr. VLADECK. Well, again, sir, I think, in general, under the President's plan, some of those folks are in States that do not now provide for extensive coverage of noncash eligibles will be better off. Those from States with more generous coverage will not be as well off.

It is part of the reason that the President personally felt very strongly about ensuring this federally managed wraparound benefit for low-income children; to ensure that no low-income child anywhere in the United States was any worse off as a result of any of these changes. And I think we have been quite careful to protect those kids in terms of the range of services they will have available to them and so forth.

The availability of Medicaid-paid services or benefits to the noncash assistance will remain at the States' discretion, and we expect some of the States that have been traditionally more generous in that regard will continue to provide some of those services.

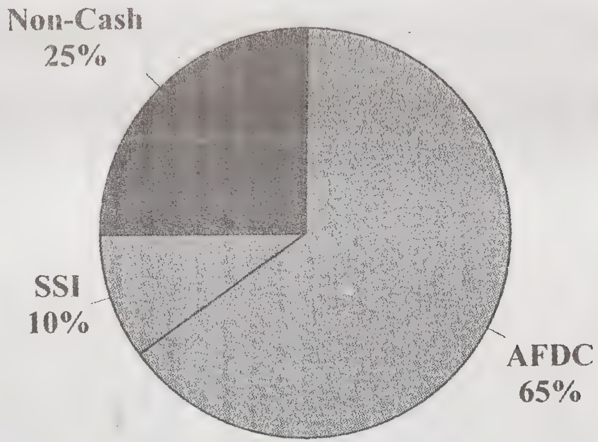
Mr. WYDEN. I hope you all look at it again. I note the chart, Ms. Rowland's chart. We are talking about 25 percent of the people: Noncash employed, 17 percent; noncash unemployed 8 percent. You are saying those folks are not going to be worse off? They are still not going to be getting the help in the area of cost sharing assistance. I hope that you will all look at it again.

Just one quick point on the Oregon situation. When you were here earlier, you indicated the administration had not come to a position with respect to ERISA waivers. Now, this again is essential to get people help quick; get people help now, in Oregon and Tennessee, rather than waiting until 1998.

Has the administration come to any further thoughts with respect to ERISA waivers? Since I plan to introduce Oregon's ERISA waiver bill in the next 1 or 2 days, it would be helpful to have your views.

[The charts referred to by Mr. Wyden follow:]

One in Four Current Nonelderly Medicaid Beneficiaries Would Not Receive Cost-Sharing Assistance

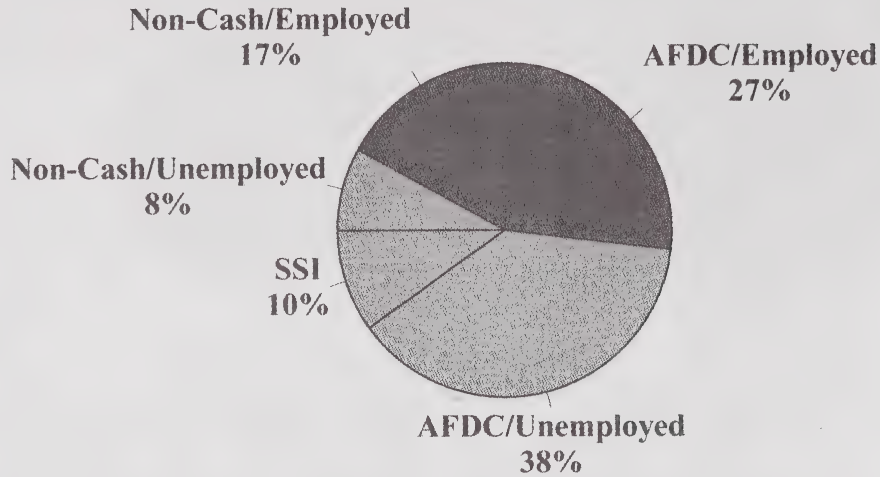


Total = 23.4 Million in 1991

Source: Urban Institute, 1993.

Kaiser Commission on the Future of Medicaid

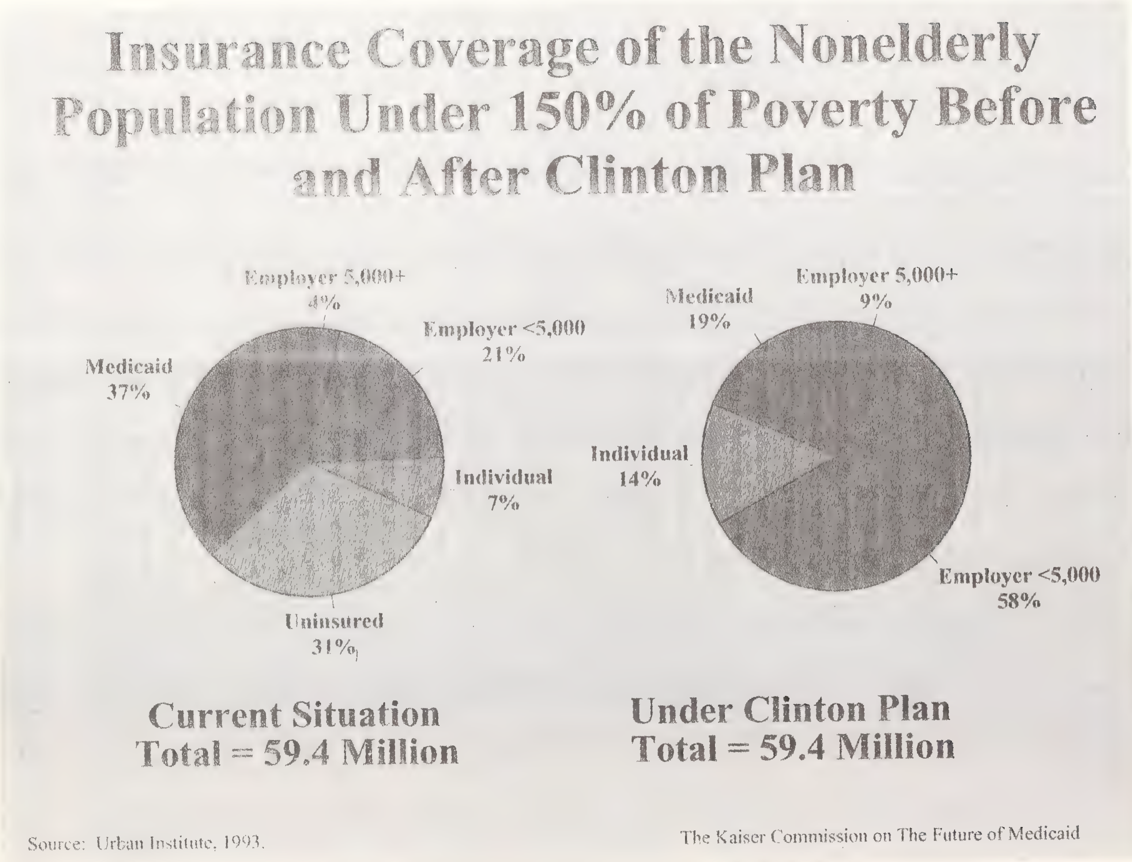
Nearly One-Half of Current Nonelderly Medicaid Beneficiaries Are in Working Families



Total = 23.4 Million in 1991

Source: Urban Institute, 1993.

Kaiser Commission on the Future of Medicaid


Insurance Coverage of the Nonelderly Population Under 150% of Poverty Before and After Clinton Plan
Employer 5,000+ 4%
Employer <5,000 21%
Medicaid 37%
Individual 7%
Uninsured 31%
Current Situation
Total = 59.4 Million
Employer 5,000+ 9%
Medicaid 19%
Individual 14%
Employer <5,000 58%
Under Clinton Plan
Total = 59.4 Million
Source: Urban Institute, 1993.
The Kaiser Commission on The Future of Medicaid

Mr. VLADECK. Again, to clarify what I think I said, we are in support of ERISA waivers, but whether as a strategic matter we want to continue to implement that through health care reform or look at special legislation is still an open question for which I am afraid I cannot still give you a definitive administration view.

Mr. WYDEN. Let me offer the judgment that I think it would be good strategy to support this since the subcommittee, Mr. Cooper from Tennessee, others from Washington and elsewhere, are going to have a considerable interest in this.

One last question, if I might. Again, in the effort to look at helpful suggestions, I wonder if we should not protect current Medicaid saving features during the phase-in of the new program, and particularly we might look at some changes with respect to the prescription drug program. You know, we have been steadily losing our best priced discount savings as companies eliminate their deepest discounts. This is costing Medicaid something like $1 billion over 5 years.

What would you think of the idea of Medicaid converting to a flat rebate discount so that we could, again, make sure that we tap the full possibility of Medicaid prescription discounts?

Mr. VLADECK. I would have to think further about that particular issue. Again, our general feeling, and we discussed this very briefly in terms of the Medicare drug benefit yesterday, and I imagine we will have the opportunity to discuss it further in the future, is to leave the plans and as much, the States in the interim, negotiating leverage as we can relative to the manufacturers, unconstrained except as a backup by formulistic kinds of determinations.

But in terms of your specific recommendation, I would be happy to think about it further, look into it and respond.

Mr. WYDEN. My only point, and then I want to recognize my colleagues, is let's not give these huge drug companies another windfall during the transition and I am afraid that is what your proposal does.

Mr. VLADECK. We will look into that.

Mr. WYDEN. Good.

The gentleman from North Carolina.

Mr. MCMILLAN. Thank you.

Mr. Vladeck, the total Medicaid budget this year will be, what, about $90 billion?

Mr. VLADECK. The Federal share, sir.

Mr. MCMILLAN. You stated there are 30 million beneficiaries under the system, so the per capita cost is around $33,300 per capita.

Mr. VLADECK. Yes, that is true, although——

Mr. MCMILLAN. I know that is an oversimplification but I want to get it in proportion because the guarantee package is $1,800 per capita, as a general rule, is the assumption. All I want to get at here is what else do we have in that that throws it well above the norm in terms of per capita cost? Is it the fact we have a lot of long-term care we are reimbursing through Medicaid, for example?

Mr. VLADECK. Yes, sir, that is primarily it. I think about—let me see if I can get the number in rough order of magnitude, although I am sure Diane Rowland knows it off the top of her head—but I think about 20 percent of all Medicaid recipients at any given time

are in long-term care institutions, whether nursing homes or ICF/M R's, and they account for more than 40 percent of total Medicaid expenditures.

The average cost nationally for Medicaid-covered nursing home services is on the order of $20,000 or $25,000 a year. So our cost per capita for AFDC mothers and kids is a lot closer to that $1,800 number. It is not exactly it, but it is a lot closer than $33,000.

Mr. McMILLAN. You made the point earlier we are not running a local school board here and saying a penny on the tax rate goes for this, and that everything is fungible. We got into this yesterday on Medicare savings.

Presumably, under your assumptions, a big chunk of what is classified as Medicaid that goes for long-term care will be covered under Medicare in the incremental expenditures that are projected there for long-term care; is that correct?

Mr. VLADECK. With a minor correction, sir. Much of the new long-term care benefit is not a Medicare benefit but it is the new benefit. But it will not be part of the Medicare program. It will not be in title 18.

Mr. McMILLAN. Then what is in the $131 billion of incremental Medicare expenditures we discussed yesterday?

Mr. VLADECK. To the extent we discussed them as incremental Medicare expenditures, that may have been misleading. They are incremental expenditures for Medicare beneficiaries, of which net, about half of that $130 billion figure, was for the drug benefit, and the other half for the Federal share of the long-term care benefit, which will be primarily for Medicare beneficiaries but will not technically be a part of the Medicare program.

Mr. McMILLAN. Well, that is complicated to cover here, but I think in an analysis of our savings and reallocation in both programs, we need to clarify what in fact may well be fungible between those two programs so that we are not misled into talking about them in isolation one from the other, because I think that confuses the issue.

I am not accusing you of that. I think we all have to get to that point of understanding.

Mr. VLADECK. If I may just quickly. There are some very complicated interactions between the new long-term care benefit and existing Medicaid community-based long-term care services, and we are working on those estimates but it is a very complicated thing to try to figure out.

Mr. McMILLAN. But going to the assumption that there are $65 billion in Medicaid savings, we will call them, which really become then a reallocation into the new system, what I would like to—and I would like to ask a few questions along those lines—will the disproportionate share program still be retained?

Mr. VLADECK. The Medicaid disproportionate share program will phase out on a State-by-State basis as States implement the new system.

Mr. McMILLAN. Then will there be a disproportionate share of distribution State by State? Will there be a community-based cost estimate that will preserve, in effect, the same disproportionate share of Federal funds flow in their respective States?

Mr. VLADECK. No, sir.

Mr. McMillan. OK. Because my perception would be there are States who have taken advantage of that to an extraordinary degree, and that came out in this year's budget, and I know that again is complicated and probably very sensitive, but that is something I think we need to zero in on as we proceed through this.

Mr. Vladeck. If I may?

Mr. McMillan. Has my time expired?

Mr. Vladeck. The disproportionate share payments are included in the calculation of the base of State expenditures on which the State maintenance of effort is calculated, so that States are tied to their current level of disproportionate share expenditures in terms of their share of payments in the new system, but the alliances and the plans do not receive any particular benefit from prior disproportionate share treatment.

Mr. Waxman. Thank you, Mr. McMillan.

Mr. McMillan. Thank you.

Mr. Waxman. Mr. Brown.

Mr. Brown. Thank you, Mr. Chairman.

Mr. Vladeck, my understanding is the plan would make payments to the States for those populations based on prior levels of spending for populations in a State; correct?

Mr. Vladeck. Yes.

Mr. Brown. I have a couple of questions related to that. First, it seems likely that both the removal of the stigma of Medicaid and the guarantee that patients will receive care when they seek it because physicians will be paid by the plan, not by Medicaid, would increase access and concurrently increase the cost of care for those patients; correct?

Mr. Vladeck. Well, we believe it will increase access. Again, our experience with Medicaid managed care suggests that for mothers and kids, increased access can generate lower cost because of better primary care and reduced reliance on emergency rooms and episodic treatments.

Mr. Brown. Isn't that, particularly the first part of that, this sort of preventive care; that that is not cost saving immediately? The emergency room part of your answer is correct, but that is not really—don't you need—I guess I should ask it this way.

Shouldn't that be factored into the payment scheme to the States; that there will be at least initially larger costs because of that?

Mr. Vladeck. Again, our experience with Medicaid managed care is now very extensive to suggest good managed care plans do save money over a relatively short period of time; not dramatic amounts of money, but that increase in total utilization is more cost effective.

For example, for this population, far and away the most important and cost-effective preventive service is prenatal care, and it does not take a long time to realize the economic benefits of that.

So I think our estimates of the economics of this suggest that, again, on a per capita basis, we think there is enough money now in the Medicaid system in most States to pay for better, higher quality care for folks who are not now getting it. Obviously, there are a lot of folks who are not getting care at all, and they will represent incremental access and incremental costs.

Mr. BROWN. So for those people already getting care, you can expand their care, full, prenatal, child immunization, get them from emergency rooms to clinics; you can actually serve the same number of people more intensively, if you will, or more frequently, if you will, for the same or less cost?

Mr. VLADECK. Yes, sir, and again we have some experience that suggests we have actually been able to do that.

Mr. BROWN. Tell me about that briefly.

Mr. VLADECK. Again, we have had a number of evaluations of our Medicaid managed care projects in a number of States. The experience is somewhat variable. Some managed care organizations are much better than others, some State programs have worked better than others, but we have seen a pretty consistent pattern in the higher quality plans of savings of up to 10 or 15 percent on a recurring basis.

Mr. BROWN. So you are satisfied you have factored in the whole issue of the stigma of Medicaid and the guarantee that patients will receive care. You have factored this all in and are satisfied internally, if you will, satisfied that the cost factors are all considered there?

Mr. VLADECK. On a per capita basis, yes, sir.

Mr. BROWN. OK. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

I am wondering what the interjection is of this administration's promise to make health care a right, not a privilege, and its promise to end welfare as we know it. The administration has said that in the course of welfare reform, it plans to reduce incentives for dependency on the welfare state and, at the same time, wants to make sure that the poor are not discriminated against when it comes to health care. Can you respond to that?

Mr. VLADECK. I would be happy to. I have to be a little careful not to encroach on other jurisdictions within the Department, but the Secretary has said often enough that the cornerstone of welfare reform is health care reform.

We do believe there are many instances in which people who have the opportunity to leave the welfare system and enter the labor market are deterred from doing so because of the potential loss of Medicaid coverage. We also believe that the costs of health insurance to small- and low-wage employers, who are often the first entry point for folks leaving welfare into the labor market, discourage them from having health insurance and make the choice for the person on welfare much more difficult.

All the discussions we have had with States on demonstration projects on welfare reform in the prior administration, as well as those we are now conducting, have very critically hinged on what happens to Medicaid coverage and on the ability, in fact, under current law, to extend Medicaid coverage in the particular instance of a person who has been on welfare and goes to work and would otherwise be ineligible for Medicaid as a result. But we allow a special transition because we know how critical it is.

So all the welfare reform experts tell me that universal coverage is a very, very important step in getting people off of welfare.

Mr. GREENWOOD. Looking at it another way, health care is a very valuable and precious commodity. It appears that regardless of an individuals willingness to work, criminal behavior, substance abuse, or willingness to pay child support, et cetera, there is virtually nothing under this proposal you can do wrong that will prohibit you from getting first class health care. Is that right?

Mr. VLADECK. That is right, but I think that is true in the current circumstance. Indeed, I think there are a number of positive disincentives to work and certainly to work part-time or to work in entry level employment in the current intersection between the welfare system and the health insurance system.

And I am reasonably confident that this proposal, whatever else it does or does not do, straightens out those incentives in terms of not punishing people for working.

Mr. GREENWOOD. Let me shift gears.

I am very interested in the traumatically brain injured population, particularly those to whom that event occurs later in life. Can you tell me how the program would provide care for those individuals?

Mr. VLADECK. Again, that continues to be tied to the question of eligibility for cash assistance or for other basic other forms of assistance in the sense that persons who are eligible for Social Security disability payments and therefore eligible for Medicare are Medicare beneficiaries entitled to Medicaid wraparound if their income is low enough.

If they have employment-based disability policies at the time they incur the head injury, then the employer-based disability coverage is generally primary for whatever health-related coverage it has, as long as that lasts; with Medicare as the secondary payer until that coverage expires or is discontinued, in which case Medicare becomes the primary payer when the person qualifies for social security disability and becomes Medicare eligible, with Medicaid as a secondary payer if the person has low enough income.

We do have a problem, as we do now in a number of States, for folks who do not qualify because of work history or for whatever reasons for Social Security disability. Currently, if they are of low enough income, States cover a very broad range of services for them under Medicaid.

Under the President's proposal, the basic benefit package will continue to be an entitlement. But for that much smaller subset of this entire population, whether or not Medicaid covers those services and then the alliance does not, will be a State option.

Mr. GREENWOOD. The problem frequently is not whether or not there is coverage for the service but the kind of service that is covered. Medicaid, historically, I believe covers relatively unsophisticated nursing home care for the traumatically brain injured. It does not cover the sophisticated cognitive rehabilitation that is available in the health care system, but is usually only paid for by fairly generous programs or as a result of lawsuits.

Do you anticipate that this health care reform plan will improve the level of sophistication of the benefit that is available for these individuals?

Mr. VLADECK. I don't want to go too far out on a limb relative to this particular condition or particular treatment modality, par-

ticularly because I understand they are evolving very rapidly. But the proposal does require that the Secretary enumerate a number of highly specialized services and identifies providers of those services, and that plans must contract with providers of those services for those who need them.

This provision originates from transplant centers, for example, but the logic of it applies to specialized brain injury rehabilitation or other specialized rehabilitative services as well.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Vladeck, Diane Rowland is going to testify in a short time that one in four current nonelderly Medicaid beneficiaries, roughly 6 million individuals, many of whom are pregnant women and young children, would not receive cost sharing assistance under the President's plan.

What is the policy logic of this? Are these low-income people somehow better able to afford the cost sharing expected of them under the President's plan than those who are on cash assistance?

Mr. VLADECK. Let me try to clarify what I understand the policy to be.

For those persons under the President's plan below 150 percent of the poverty level, they will have the option of enrolling in the low cost sharing plan where we are talking about $10 for a physician visit and similarly relatively low coinsurance for everything other than emergency room visits.

In our view, in the picture of the entire plan, while that is a greater out-of-pocket expense than they now encounter, it is not an unreasonable level, given the enormous variables from one part of the country to another, as we try to establish some basic uniform national standards.

Mr. WAXMAN. So those who are on cash assistance, will receive some help with their out-of-pocket costs and those who are poor but not on cash assistance will not?

Mr. VLADECK. There is different treatment of them, yes, sir.

Mr. WAXMAN. And the rationale is?

Mr. VLADECK. Again, the rationale is to be as generous as we can within some fiscal constraints in a uniform national policy, given where we are starting from at the moment.

Mr. WAXMAN. Later today the National Health Law Program will testify that the different treatment of cash assistance recipients and other poor people will punish people who work because low-income mothers who leave AFDC for employment will pay more in premiums and cost sharing for their basic coverage.

They also point out that the link to cash assistance will create irrational disparities because of widely varying AFDC eligibility standards. The result is that families in identical need will be subject to different financial burdens under this plan solely because of the welfare eligibility standards in the States in which they live. Can you explain the policy thinking regarding this?

Mr. VLADECK. Again, I believe our proposal reduces existing disparities and I think we have gone as far, frankly, as we thought we could afford in a reduction of disparities for who gets covered and who pays what and has what out-of-pocket liabilities.

I think with post health care reform there will continue to be disparities, but they will be fewer less than those that now exist.

Mr. WAXMAN. How much money would it cost to remove this disparate?

Mr. VLADECK. I honestly do not have a figure off the top of my head, but we can try to get one for you, sir.

Mr. WAXMAN. OK. Thank you very much.

[The information follows:]

In response to the chairman's request for an estimate on the cost of eliminating disparities in cost sharing and premium subsidies for non-cash assistance Medicaid recipients, we have the following information to report.

The estimated additional cost of providing cost-sharing and premium subsidies to non-cash Medicaid recipients below 150 percent of poverty, in 1994 dollars, is $473 million. This estimate was computed as the difference between the full cost sharing in a lower cost sharing plan and 20 percent of the cost sharing in a lower cost sharing plan. Any cost sharing above the full cost sharing levels will be subsidized through the standard subsidy to families below 150 percent of poverty.

This group would currently be eligible for $4.1 billion in standard premium subsidies under the plan. Providing the additional premium subsidies would cost another $553 million. This corresponds to the amounts that would be the families' remaining responsibility under the plan, and includes both the 20 percent family share and any unpaid employer share.

Mr. WAXMAN. Mr. Bliley.

Mr. BLILEY. Mr. Vladeck, many of the witnesses today point out that the administration's Medicaid proposal will effectively force the poor into low cost sharing HMO's. This chart, however, explores the opposite possibility.

The fact that in some situations the fee-for-service plans will have the lowest premium and none of the managed care plans will have premiums at or below the average weighted premium, in this example the alliance offers the following plan: One, Blue Cross/ Blue Shield standard option, which is a fee-for-service plan with a total family premium of $4,891; Government Employees Health Insurance, which is a fee-for-service plan, with a family premium of $5,018; and a Maryland IPA, which is an HMO with a premium of $5,500.

Assuming equal number of recipients in each plan, the average weighted premium for the alliance would be $5,136. If a Medicaid cash eligible recipient chose either of the two fee-for-service plans, Medicaid would pay 100 percent of the premium. However, if the Medicaid recipient chose the HMO, they would have to pay $364 out-of-pocket, which is the full cost of the amount by which the premium exceeds the average.

Now, let's look at some of the implications that follow. First, Medicaid recipients lose freedom to choose plans because they cannot afford additional premiums in choosing the HMO, which is the low cost sharing plan. Because Medicaid recipients are funneled into plans based on premium cost alone, there is a disincentive to enroll in managed care, which has a lower cost sharing.

However, in this example, because there were no managed care plans at or below the average weighted premium, the Federal Government must provide subsidy payments to the alliance which buys down the cost sharing to the level of the managed care plan.

Finally, the administration bill would make the health plan further subsidize the recipient. Plans would further have to subsidize

80 percent of the cost sharing. This could result in health care plan shortfalls or an unwillingness to accept cash eligible enrollees.

Mr. Vladeck, clearly the intention of the plan is to have Medicaid recipients and other poor people choose the HMO's with cost sharing based on a per visit rather than a percentage basis as under fee-for-service. However, in this example, it is the fee-for-service plans with high cost sharing, not the HMO plan, that has the lowest premium.

If the Medicaid recipient chooses the low cost sharing HMO, he is penalized because he has to pay an additional premium. Would you please comment?

Mr. VLADECK. Yes, sir, believe it or not, we thought of this one, and I think we have an answer. Let me just say it is not the intention of the plan, per se, to drive Medicaid recipients into HMO's as it is the intention of the plan to encourage them into the low cost plans in their communities.

In those communities in which there is no HMO available at or below the average weighted premium in the community, Medicaid recipients who pick a plan at or below the average weighted premium will have their cost sharing subsidized by the alliance to the HMO level.

Mr. BLILEY. Again, referring to this example, Mr. Vladeck, the administration would provide Federal subsidy payments to the alliances to buy down the recipient's cost sharing to the level of the managed care plan. These Federal payments would probably be substantially greater than the $364 to buy the recipient into the HMO.

Do you believe the alliance should have the option of providing a premium rather than a cost sharing subsidy in this situation?

Mr. VLADECK. I don't believe that should be the alliances response, sir. I believe if you have communities in which the fee-for-service plans are providing premiums that are significantly below the HMO's, the alliance might well want to explore inviting into its marketplace some other plans or some other providers to increase the competition and maybe put some more pressure on those higher cost HMO's as a better strategy all around.

Mr. BLILEY. Finally, Mr. Vladeck, all managed care plans are forced to subsidize cash eligible Medicaid recipients. Under your bill, plans would have to subsidize 80 percent of the cost sharing out of their pockets or their own revenues. This could lead to plan shortfalls or an unwillingness to accept cash eligibles. Don't these provisions create a Federal statutory cost shift?

Mr. VLADECK. I am always a little uneasy about the use of the term "cost shift" in any particular setting. I think they might. It would depend on how many services those folks in fact use, what the effect of a subsidized copayment was on utilization patterns, and so forth. It might, depending on the risk adjustment payment level to the plan.

Mr. BLILEY. Thank you very much. I appreciate your candor, Mr. Vladeck.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Just to close the loop on this matter of the noncash assistance recipients that I asked about, and Mr. Waxman asked about, please understand the seriousness that some of us convey this matter to you, because when welfare reform goes into effect—another top initiative of the administration—that means we will have even more folks on the noncash assistance side. So that chart I held up with the 25 percent, when welfare reform goes into effect, we will have even more people. So we want to see that addressed and are anxious to work with you.

Let me ask you about one other issue, Mr. Vladeck, that is, are you at all troubled about the prospect that poor people are going to feel uncomfortable and generally find it difficult to navigate their way through HMO's? I have had a couple of hearings in the last year where poor folks essentially come in and say they feel they are discriminated against by HMO's; that they come in with wounds and cuts and the like and they are told they are not serious and come back another time, and all of a sudden we are going to be sending poor people to these gleaming high-rise HMO's and telling them you navigate the new system.

Are you at all troubled by the prospect that poor people are going to find it hard to make their way through this kind of new health care universe? And, if so, what do you see the administration doing to try to address these needs?

Mr. VLADECK. I think that is a very real and legitimate issue, and I think more generally, it has been our experience in the Medicaid program, for example, that some of the better, more successful traditional HMO's have been no more interested in reaching out to Medicaid recipients, even under relatively generous State-run payment arrangements, than the recipients have been in knocking on the doors of the HMO's.

And any time you seek to integrate traditionally underserved, discriminated against populations into a mainstream service system, a lot of steps need to be taken to make sure that folks formerly outside the mainstream don't lose out in the process.

There are in the proposal some provisions that address some of this in a very limited way, especially in terms of some of the facilitative and outreach services under the Public Health Service-related funding in the act, and some of the general obligations on the part of States and alliances, in terms of enforcement of nondiscrimination expectations.

But I think that is a very legitimate and appropriate concern that we will need to think about, both in terms of the statute. We need to think in terms of educating the States, and the alliances, and the plans on how they need to address these situations.

Mr. WYDEN. My sense is that this is the kind of problem that we have frequently today with HMO's and I think it is going to be compounded in the future, and I appreciate your comment particularly in terms of trying to look for a bit of flexibility so that, say, a community health clinic that is out there now that had dealt with a particular population group had succeeded in coming up with an approach that was reasonable both in terms of services and cost containment, that we keep those people in the new universe.

I have had a lot of these community clinics come to me, for example, and say, look, we do not mind you putting us out of business

at all if our people are going to get served, but what we are troubled about is the fact they will be sent off to the suburban HMO, they will not get services, we are not going to be out there, and that is going to reduce access.

So your comments about trying to bring some of those people in and looking to how that might be done is a sensible one.

Mr. VLADECK. Let me just say as well, many of the traditional providers of low-income populations, including community health centers and some of the larger public hospitals, are quite plausibly developers and hubs of their own plans and their own networks under this relationship. Again, you have the classic dilemma of historically underserved communities, and do you reinforce the existing institutions at the expense of some risk of continued segregation of those populations, but ensure that they will have access to folks they know and have worked with. And we do have grant and loan funds provided in the plan to assist such traditional providers in developing such networks and being able to compete in the new system.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden. Mr. McMillan.

Mr. MCMILLAN. Just continuing that line of questioning, I really think if we succeed in creating true competition, and then those who we have classified previously as Medicaid beneficiaries are basically merged into the system with the same reimbursement levels, and able to buy into the same competitive plans, able to exercise the same choice, then if they feel uncomfortable with what someone is doing, there are other choices for them to elect. I think that is a laudable goal that we should try to achieve.

I don't think a lot of people today, if there is not adequate competition out there, feel uncomfortable moving into, say, a trauma center of a major urban hospital and to receive equivalent benefits or even those who have no benefits doing so, and that cost is getting absorbed by others and it is one of the very things I think you are trying to address to deal with. They are interrelated.

I don't know how to pursue further the question because we do not have the schedules before us in terms of trying to get a handle on total outlays that you envision under whatever we call this future subsidy. We start with $65 billion in savings. Based on the funds flow information that was provided by Ken Thorpe to the Budget Committee, which I think was prepared by your office, the total level of subsidy is difficult to put a handle on. It would appear to be probably a total of—this is not including Medicare—would include $161 billion of subsidy over 5 years—excuse me, 6 years, plus total discounts, it says, of some $349 billion. Do you recall those two figures?

Mr. VLADECK. Something on the order of a high of $400 billion a year over 5 years, the number that I was familiar with, and I think that is quite consistent with those numbers, yes.

Mr. MCMILLAN. But does the total of those two figures ring a bell in terms of total subsidy?

Mr. VLADECK. Yes, sir.

Mr. MCMILLAN. Outside of Medicare that will be the total subsidy of the system, which includes everything that we have classi-

fied as Medicaid previously, plus subsidizing anybody else in the health care alliances that fall under a certain income category.

Mr. VLADECK. Plus providing discounts to employers.

Mr. MCMILLAN. That is a total of close to $500 billion over 5 years. And in the full year of implementation, it will be on a magnitude of about $146 billion a year.

Mr. VLADECK. Sounds about right.

Mr. MCMILLAN. Which would be funded by the savings we have identified in Medicare.

Mr. VLADECK. And Medicaid and the new tax revenues and some of the other sources, yes, sir.

Mr. MCMILLAN. All right. That is what I am basically trying to get a handle on. I think you gave us good figures yesterday on Medicare savings, and we are pretty clear in terms of how that would be reallocated into long-term care and pharmaceutical payments. I think we need to do the same thing here in a little more clear fashion, because I think understanding is really the beginning of getting at this issue and having confidence in our capacity—the funding is going to have everything to do with what we do.

Mr. VLADECK. I am sorry I didn't have that kind of greater detail for you today, and I would be happy, if you ever want me back, to do it on another occasion.

Mr. MCMILLAN. Well, I want to compliment you——

Mr. VLADECK. Or do it by mail.

Mr. MCMILLAN [continuing]. Compliment you on what you have done so far and urge you on to continue. I do think it is essential—it is essential, for example, to the debate we might have on the rescission package. And we may not have it. If it looks like it is going to win, we probably will not have it. But, nevertheless, I think it is better to debate these things in light rather than darkness, even if we disagree on them.

So I compliment you on that and I hope we can follow up with that rather soon.

Mr. VLADECK. I appreciate that.

Mr. MCMILLAN. Thank you.

Mr. WAXMAN. I have the same feelings, if the gentleman will permit, not only on this issue but the Penny-Kasich issue. I think it would be better to debate it and evaluate it; have a little discussion and information. Thank you.

Mr. Brown.

Mr. BROWN. Mr. Chairman, me too. I don't have any more questions. Thank you.

Mr. WAXMAN. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

The President's health care plan requires that States maintain their current level of spending on health care, including their spending on Medicaid and portions of their public health programs. In particular, many States have been able to expand eligibility for Medicaid and offer Medicaid beneficiaries a relatively generous benefits package. I understand that States will not have an opportunity to negotiate with the National Health Board on State-specific maintenance of effort, which take into account these differences; instead, a commission is charged with making recommendations by 1995 on how to reconcile these differences.

I would be interested in hearing your perspective on this approach to reconciling the differences. Is it fair that the States and the beneficiaries perpetuate these differences around the country?

Mr. VLADECK. Sir, I think this is one of the most complicated and difficult issues in a Federal system one could encounter. And, frankly, if we thought there was a clear-cut argument on one side or another, we would probably not recommend appointment of a commission.

As you may know, Mr. Moynihan is the senior Senator from my home State and is as articulate and eloquent on some of the inequities on this issue as anyone and has been consistent over a period of time, but these issues pervade all of our programs that have joint Federal-State financial participation. I am not sure that anyone has ever found the right answer.

The disparities in State efforts in the Medicaid program are quite extraordinary in terms of State-raised dollars. New York and California, between them, which have approximately somewhat under 15 percent of the entire population in the United States, raise almost 35 percent of all the State-contributed dollars in the entire Medicaid program. On the other hand, they get back a very substantial amount of Federal dollars in the process.

So it is very complex. It gets to the very roots of a Federal system. And other than saying that, I don't have any appropriate answers, except I very much hope we can get a very high powered, high level thoughtful group together in this commission and that they will come up with something creative.

Mr. GREENWOOD. OK, thank you.

Currently, certainly States use an uncompensated care pool as the source of funds to provide disproportionate share payments to hospitals with a high volume of indigent care. The funds for these pools often come from an assessment on hospitals' bills. These poolings would likely be dismantled with the enactment of the President's plan as there would be a great decrease in uncompensated care. The assessment on hospital bills also would be eliminated.

However, I understand that States will be required to maintain their proportion of their disproportionate share program. Clearly, for many States this will be a great financial strain on their budgets. Are there any plans to ease this burden?

Mr. VLADECK. As I understand it, and, Sally, correct me if I am wrong, States do have a number of sources they use to raise money they contribute to their share of Medicaid, including an array of taxes on health care providers of a variety of kinds, and in many instances, taxes on health insurance premiums or premium payments to HMO's and so forth.

I believe, in the whole 1,300 some odd pages of the draft Health Security Act there is no reference to sources of State revenues, except to provide that a single payer State cannot go after the same revenues the Federal Government is using to finance its share of health care reform. And we are, I think, silent on purpose of State revenues to support maintenance of efforts in that regard.

Mr. GREENWOOD. That is all. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Vladeck, we are delighted to have you with us to spend another morning with us. You have been very helpful and we will look forward to other occasions when we can have not only public meetings but opportunities to work together.

Mr. VLADECK. It is always a pleasure, sir. Thank you.

Mr. WAXMAN. Thank you.

Our next witness this morning is Dr. Diane Rowland. Diane Rowland comes to us with impeccable credentials, having served on the Majority staff of our subcommittee for 4 years and as a consultant to the subcommittee for another 3 years. She is currently a Vice President with the Henry J. Kaiser Family Foundation and is also an Associate Professor in the School of Hygiene and Public Health at Johns Hopkins University. She appears before us this morning in her capacity as Executive Director of the Kaiser Commission on the Future of Medicaid.

Dr. Rowland, it is truly a pleasure to welcome you today. Your prepared statement will be in the record in its entirety. We would like to ask you, if you would, to limit the oral presentation to 5 minutes.

STATEMENT OF DIANE ROWLAND, EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID

Ms. ROWLAND. Thank you. It is a pleasure to be here today representing the Kaiser Commission on the Future of Medicaid. The Kaiser Commission would like me to focus today on four key aspects of the Clinton plan with regard to the low-income population and coverage of the poor.

First, we want to fundamentally support universal coverage as a critical component of any health care reform plan, and the commission strongly supports this aspect of the President's plan. The poor have a lower health status and higher rates of disease and disability than the nonpoor. Without insurance, they often go without care. One-third of the uninsured postponed needed care or went without it last year.

Health insurance is clearly an important lever to access the system and under the Clinton plan all Americans, including low-income Americans, will be covered. Today, 31 percent of the 59 million Americans under 150 percent of poverty are uninsured. That is 19 million people.

As my first chart shows, the current coverage of the low-income population has about 37 percent of that population on Medicaid and about 31 percent uninsured. Under the Clinton health reform plan, substantial realignment and responsibilities for coverage of the low-income population would take place.

The employers would gain new responsibility for coverage of 80 percent of the premium share. Alliances would provide coverage for the nonworking, noncash population. As this chart reveals, the 19 million uninsured low-income workers would be transferred to employers of over 5,000. Responsibility for the current Medicaid population would also be shifted to employers for those who are working.

Today, roughly 6 million AFDC individuals work and have dependents, another 3.5 million are in the noncash Medicaid population. So among the current Medicaid population, nearly one-half

are in working families, and employers will be now asked to pay some share of the responsibility for these individuals.

The other aspect of the Clinton plan I would like to focus on, which you have already covered quite well this morning, is the cost sharing policy and the lack of subsidies for the noncash population. If you look at the Medicaid population today that is nonelderly, about a quarter are noncash assistance. These are, in fact, many of the pregnant women and children who this committee has added, but there are also many of the medically needy individuals who come on to Medicaid because they have high medical expenses. They are, in fact, more expensive and use more medical care than the cash assistance population which the administration provides subsidies for.

There is no assistance under this plan with cost sharing to the 6 million noncash people currently on Medicaid, nor is there any assistance to the other 11 million low-income individuals who are not on Medicaid today and are going to be covered under the plan but without any assistance for their cost sharing. And even for those who are on cash assistance and will be eligible, they will only be covered for cost sharing in the HMO-type plans, which effectively precludes them from being able to be in a fee-for-service plan with the high cost sharing structure there.

Thus, the cost sharing structure effectively locks low-income individuals in this plan out of fee-for-service plans, even if they are the lowest premium cost plan. We believe that limiting assistance with cost sharing to cash assistance recipients perpetuates the welfare policies and State variations in the provision of medical assistance that this committee has so successfully worked to break over the past years in the Medicaid program and would urge that any assistance with cost sharing under this plan be provided not just to the cash assistance population but to all individuals on the basis of income.

In addition, we ask that you look at the combined impact of the premium structure, cost sharing, and price competition of plans on the access to adequate health insurance coverage for the low-income population and try to make provisions to allow them more choice of plan under a fee-for-service-type plan.

Finally, we would ask that you also look at the responsibilities being asked of alliances under this plan. Ninety-one percent of the 59 million low-income Americans will receive their care through a regional alliance. These alliances are untested concepts and we have concerns that they may not provide some of the kind of outreach services as well as many of the counseling and enrollment services required of a low-income population.

In conclusion, we think the Clinton plan takes a bold and progressive step forward in its complement to universal coverage and to bringing all Americans under the same system of care, but look forward to working with this committee and with the administration to improve the protections for low-income people. Thank you.

Mr. WAXMAN. Thank you very much for your excellent testimony. I want to commend you on that presentation.

[Testimony resumes on p. 601.]

[The prepared statement of Ms. Rowland follows:]

Diane Rowland, Sc.D.

Testimony before the Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives
November 19, 1993

Thank you, Mr. Chairman and members of the Committee for this opportunity to testify on behalf of the Kaiser Commission on the Future of Medicaid on the health needs and implications of health care reform for low-income Americans. I am Diane Rowland, Senior Vice President of The Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission was established by The Henry J. Kaiser Family Foundation in 1991 to function as a Medicaid policy institute and serve as a forum for analyzing, debating, and proposing future directions for health care for poor and vulnerable populations. The fourteen member bi-partisan national commission is chaired by James R. Tallon,Jr., President of the United Hospital Fund of New York and former Majority Leader of the New York State Assembly.

I am pleased to be here today to share the work of the Commission and to discuss the implications of health care reform for the low-income population. My statement reviews the health status of our nation's poor, the current gaps in health insurance coverage of the poor, and the importance and likely impact of health care reform.

Why is Health Care Reform Important to Low-Income Americans?

In 1991, 32 million Americans -- 15 percent of the non-elderly population ---

lived in poverty (Figure 1). For a family of three, this means struggling to pay for health and medical bills as well as for food and housing on an income of less than $11,000 a year. Another 40 million Americans live on the edge of poverty with incomes between 100 and 200 percent of the poverty level. Nearly half (45 percent) of all Americans in poverty are children; one in five American children live in poverty. Minority children are particularly at risk of growing up in a poor household. Almost half (47 percent) of black children and 41 percent of Hispanic children are poor compared to 17 percent of white children (Figure 2).

Poverty and poor health are, unfortunately, inextricably linked in America. This link is demonstrated by lower self-reported health status and higher rates of disease and disability among the poor in contrast to the non-poor. Lack of insurance among the poor often compromises access to needed care. Health care reform provides an important opportunity to address these disparities by improving insurance coverage and access to care for all Americans.

<u>Health Status</u>

The low-income population is more likely to experience poor health than those with higher incomes. Among the non-elderly population, nearly one quarter (23 percent) of poor Americans rated their health as fair or poor in contrast to only 10 percent of those with incomes above 200 percent of the poverty level (Figure 3). Eleven percent of poor children compared to 4 percent of non-poor children are in either fair or poor health.

The association between poverty and poor health is reflected in high rates of

acute and chronic conditions among the poor. Rates of heart disease and diabetes for the poor are nearly twice the levels of the non-poor (Figure 4). Infectious diseases, including HIV and tuberculosis, are also disproportionately found in low-income communities (Fife and Mode, 1992; Centers for Disease Control, 1992). These acute illnesses and chronic conditions often require on-going medical treatment and management and can lead to severe disability and even death without appropriate and timely care.

Poor children, especially those in inner-cities and medically underserved areas, are particularly at risk for certain health problems. Inadequate prenatal care and environmental factors combine to leave many children impaired throughout life by conditions that are preventable during youth. Poor women are at higher risk of having babies of low birthweight, a leading cause of infant mortality and disability. In New York City, a recent study found that twice as many low birthweight births occurred in the poorest neighborhoods as in the wealthiest neighborhoods (Greater New York March of Dimes, 1993).

Children born into poverty are also less likely to receive health services which could prevent diseases in later life. Only 38 percent of poor two year old children are fully up-to-date on their immunizations compared to 61 percent of children above the poverty line (Children's Defense Fund, 1991). Rates of both pneumonia and frequent diarrhea -- potentially dangerous childhood diseases that are treatable -- are also higher among poor children (Hardy, 1991).

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<u>Health Insurance Coverage</u>

Having health insurance coverage to help provide the financial means to pay for medical care is an important component of assuring access to health care for all Americans. Without insurance coverage or sufficient income to purchase care, it is difficult to obtain timely and appropriate treatment and preventive and primary care. Yet, in the United States, more than 35 million people are without insurance coverage and millions more are at risk of losing their coverage. Having insurance coverage is highly dependent on whether and where you or a member of your family works or whether you are aged or poor enough to qualify for public assistance for health coverage.

Given their lower health status and greater expected need for medical care, it is critical that low-income families have protection against large medical expenses and the broadened access to care that insurance provides. The poor are, however, at greater risk of being uninsured than the nonpoor. A third of the 32 million non-elderly Americans in households with incomes below the poverty level and 29 percent of Americans with incomes between 100 percent and 200 percent of poverty are without insurance (Kaiser Commission 1993). The poor not only are more likely to be uninsured than the nonpoor, but also are more likely to have a lapse in insurance coverage. Over a two year period, more than half of those in poverty compared to 15 percent of the non-poor were uninsured for at least one month (Bureau of Census, 1991).

Medicaid, our joint federal-state program for financing health care for the low-

income population, provides health insurance protection to 23 million non-elderly Americans, but still covers less than half (48 percent) of the non-elderly poverty population (Figure 5). Congressionally-mandated expansions have broadened Medicaid coverage beyond traditional welfare categories to include two-thirds of all poor children and require coverage for pregnant women with incomes below 133 percent of poverty. However, poor adults without children are still categorically ineligible for Medicaid unless they qualify as disabled under the Supplemental Security Income (SSI) cash assistance program. State variations in income and resource eligibility levels result in wide variations in the percent of poor covered by Medicaid. The income criteria for Medicaid eligibility ranges from 77 percent to 16 percent of the federal poverty level with eligibility levels below 50 percent of poverty in 35 states.

Despite the variations in eligibility across states, Medicaid coverage is essential to the poor because few have access to private health insurance -- even if they are employed. More than half (55 percent) of the 32 million poor are workers or dependents of workers, but only 9 percent receive employment-based insurance. Even the poor who work all year at full-time jobs are not guaranteed employer-based coverage. Only a quarter of poor full-year, full-time workers and their families receive employer-based coverage (Figure 6). This disparity results from the greater likelihood that poor individuals work in low-wage jobs and small firms that do not offer health insurance.

Underlying the disparities in coverage by income and employment are regional and racial differences. Individuals in minority groups are more likely to be uninsured

than whites regardless of their income. In 1991, 33 percent of Hispanics and 22 percent of blacks were uninsured compared to 12 percent of whites (Kaiser Commission, 1993). The southern states also account for a disproportionate share of the uninsured; one-third of the American population lives in the southern states, but residents of these states account for 42 percent of the uninsured population (Congressional Research Service, 1993).

Impact of Health Insurance on Health Utilization

The lower health status of the poor would generally be expected to result in higher medical care utilization rates for the poor in contrast to the non-poor. In fact, the opposite is true. The benefits of the American health system are not uniformly available and utilized by all residents. Americans experience different health care utilization patterns that cannot be explained by health status variations alone and appear more related to insurance coverage and the availability of financial resources than health care needs.

Americans without insurance are more likely to forego or postpone needed care than those with insurance. A third (34 percent) of the uninsured reported that they went without needed medical care during the past year in contrast to 8 percent of the privately-insured population and 10 percent of those with Medicaid. Moreover, 71 percent of the uninsured in contrast to 21 percent of those with private insurance and 28 percent of the Medicaid population said they postponed needed care (Figure 7).

Comparisons of medical care utilization between the poor and the non-poor under age 65 using data from the 1987 National Medical Expenditure Survey also

reveal striking differentials in access to care by income and insurance status. For most indicators of access to care, the poor lag behind the non-poor and within the poverty population, the uninsured lag considerably behind those with Medicaid or private insurance.

Despite their lower health status, the poor are less likely than the non-poor to have had a physician contact for either preventive care or medical treatment over the past year. More than a third of the poor (35 percent) compared to 27 percent of the non-poor had no physician visits in the prior year (Figure 8). This indicates the poor are perhaps encountering financial or physical obstacles to obtaining initial access to the health care system.

Insurance coverage plays a crucial role in assisting low-income people in obtaining access to health care services. Among the poor non-elderly population, half of those who were uninsured had no physician visits in the prior year compared to one third (32 percent) of the privately insured and 22 percent of those with Medicaid. For the poor who had at least one physician visit during the year, use by the uninsured was notably lower than for that of those with insurance. The uninsured poor averaged only 4 visits per year compared to 6 visits for the poor with private insurance and 8 visits for those with Medicaid coverage (Figure 9). The higher visit rates for Medicaid reflect the disproportionately sicker population covered by Medicaid, including those who become eligible for coverage as a result of high medical expenses.

Having a regular source of medical care is often viewed as a measure of

improved access to care because a stable medical provider relationship can help foster use of preventive care and early intervention for treatment of disease. One third of uninsured poor Americans are without a usual source of medical care compared to 16 percent of those with Medicaid coverage. Despite its many problems in securing provider participation for its beneficiaries, Medicaid beneficiaries none-the-less are more likely than both the uninsured and the privately-insured poor to report a usual source of care (Figure 10).

Lack of insurance not only reduces utilization of health care services but also limits choice of health care providers. Many of the uninsured poor turn to community health centers, hospital out-patient departments, and emergency rooms for their care. Nearly one in five physician visits (19 percent) by the uninsured poor were to hospital outpatient departments compared to 9 percent of the visits by the poor with private insurance (Figure 11).

Lack of health insurance coverage has serious consequences for access to care for the uninsured population. Without health insurance coverage or available cash, many of the uninsured neglect obtaining preventive care and turn to the hospital emergency room when a medical emergency arises. Often care is not received until conditions have worsened, resulting in more serious illness and expensive treatment when care is ultimately rendered. Health insurance coverage is an important lever to access the health system. Without that access, the uninsured have limited choices regarding when and where they can obtain medical care.

What are the Implications of the Clinton Plan for the Poor?

The Clinton health reform plan seeks to provide universal coverage to a standard comprehensive set of medical and health benefits to all U.S. citizens and legal residents. To assure universal coverage for all Americans, the plan combines an employer mandate requiring all employers to offer and contribute to the cost of health insurance coverage for their employees and dependents with an individual mandate for the purchase of insurance. Enrollment in health plans would take place primarily through regional health alliances in each state that would negotiate with health plans on behalf of consumers and employers.

Under the Clinton plan, the low-income population like all other Americans would be provided universal coverage through health plans offered through regional health alliances. Medicaid coverage for acute care services for the low-income population would essentially be replaced by the new system. Low-income employed individuals and their families would be covered through either the regional alliance where they live or a corporate alliance if they work for an employer with more than 5,000 workers. Unemployed low-income individuals and families would be covered through the regional health alliance. Assistance with the family share (20 percent) of the premium would be provided to individuals with incomes below 150 percent of the federal poverty level. Employers would be responsible for paying 80 percent of the average premium cost in the alliance area for their workers and dependents.

Medicaid would retain responsibility for medical assistance to the cash assistance welfare population. Medicaid would pay the full premium share for cash

assistance recipients of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). Cash assistance recipients would also receive assistance with cost-sharing and supplemental benefits, such as dental or vision care. Former Medicaid beneficiaries who are not receiving cash assistance would no longer be covered by Medicaid and would not receive assistance with cost-sharing or supplemental benefits. They would either be covered through their employer or subsidized by the regional alliance. A new federally-funded program would be established to provide benefits to supplement the basic package for low-income children now covered by Medicaid, but not on cash assistance.

The Clinton plan would thus mean a major restructuring of responsibilities and benefits for the low-income population. Medicaid acute coverage would be replaced by the new system, employers would gain increased responsibility for their low-income workers and their dependents, and responsibility for coverage of current Medicaid beneficiaries would be shared by state governments and the new alliances. Long-term care services as well as coverage of the dual Medicare and Medicaid eligibles would remain Medicaid responsibilities.

Role of Employers and Medicaid in Coverage of the Poor

The Clinton proposal significantly improves coverage of the low-income population by mandating universal coverage and a standard benefit package for all Americans. It provides health insurance protection to 36 million uninsured Americans -- 60 percent of whom have incomes below 200 percent of the poverty level -- and eliminates the risk of being uninsured for millions more. Today, a third of poor

Americans and 29 percent of near poor Americans are uninsured -- covered neither by Medicaid nor private employer-based insurance. Under the Clinton plan, they will now be covered by their employer or through their regional health alliance.

Through the employer mandate and the creation of health alliances, the Clinton plan restructures health insurance coverage and substantially alters Medicaid responsibility for the low-income population. Subsidies and assistance to low-income people under the plan are generally available on a sliding scale basis for those with incomes below 150 percent of the federal poverty level or roughly $15,000 for a family of three. Approximately 59 million Americans would qualify for assistance as using this definition of low-income. Two-thirds of the 59 million low-income Americans would be covered by employer-based coverage, 19 percent would have Medicaid premium payments because they are cash assistance recipients, and 14 percent would be covered in the alliance on an individual basis (Figure 12).

Under the Clinton plan, the employer mandate shifts the payment of the 80 percent employer share of premiums for 10 million current Medicaid beneficiaries to employers. Roughly half of all current Medicaid beneficiaries would now be covered through their employers. In addition, more than 70 percent of the uninsured population with incomes below 150 percent of the federal poverty level -- 13 million people -- would gain coverage through their employer. Employers would also have responsibility for paying the employer share of premiums for this population. The new responsibility for current Medicaid beneficiaries and uninsured workers and their families essentially triples employer coverage from current levels for the low-income

population.

Medicaid responsibilities for medical coverage under the plan primarily relate to coverage of cash assistance recipients under the AFDC or SSI programs. These individuals represent three quarters of the current Medicaid population (Figure 13). For the 11 million unemployed cash assistance recipients and their dependents, Medicaid pays the full premium cost. For the five million employed cash assistance recipients, both Medicaid and the employer contribute the employer share (80 percent) of the premium and Medicaid covers the family share (20 percent) of the premium.

Under the plan, assistance with cost sharing is only provided to cash assistance recipients covered under Medicaid. For cash assistance recipients, cost sharing in an HMO-type plan is reduced from $10 per visit to $2 per visit. No assistance is provided in the fee-for-service plan with its $400 family deductible and 20 percent cost sharing, unless the alliance certifies that there are no HMO plans available in the area.

The six million Medicaid beneficiaries not on cash assistance today -- one quarter of the non-elderly Medicaid population -- would no longer be covered by Medicaid. The non-cash Medicaid population would receive no assistance with cost-sharing regardless of the plan chosen. For the non-cash assistance population, required cost-sharing levels would dramatically exceed the nominal levels permitted under Medicaid, especially if a fee-for-service plan were selected.

The regional health alliance plays a dominant role in the selection and negotiation of health plans for both low income and higher income Americans. The

regional alliance would have responsibility for enrollment, selection, and monitoring of health plans, functions now performed by Medicaid for the low-income population. Under the Clinton plan, 91 percent of the 59 million Americans with incomes below 150 percent of the federal poverty level would be covered through the regional health alliance where they live. Nine percent of the low-income population has a work attachment to an employer with 5000 or more employees and could potentially be covered through a corporate alliance.

Implications of the Clinton Proposal for the Low-Income Population

The Clinton plan takes a bold and progressive step forward in its commitment to universal coverage and comprehensive benefits with an emphasis on primary care and preventive services. Full coverage of all Americans regardless of income level, employment status, or state of residence will bring an end to the variations in eligibility and coverage of the low-income population under Medicaid today. Universal coverage to bring all Americans under the same system of care holds great promise for addressing the differentials in access to care and the inequities in today's health care system.

In fashioning an approach to reform the health system, it is, however, important to recognize that all Americans are not equal with regard to either health needs or ability to share in the cost of health care. The poor are by definition without the economic means to meet financial obligations. They are also more likely to be ill and need more medical care than other Americans. Thus, most of the poor are likely to face large and potentially onerous financial obligations under any plan that requires

substantial cost-sharing and out-of-pocket payments.

The Clinton plan would require significant cost-sharing by most low-income Americans. Only cash assistance recipients would have reduced cost-sharing levels and then only if they joined an HMO-type plan. No assistance is provided for anyone who chooses a fee-for-service plan regardless of income or cash assistance status unless there is no HMO option available in the alliance area.

Subsidies for premiums are limited to a sliding scale amount based on the average weighted premium in the area. The additional cost of any plan in excess of the average weighted premium is not subsidized and must be paid by the family. Many of the HMO-type plans with the lower cost-sharing amounts could be higher in premium cost than the fee-for-service option.

The implications of this subsidy policy for the low-income population requires further examination. The premium and cost-sharing levels in the plan may prove burdensome for low-income people and compromise access to care for those with health problems who use the most services.

Moreover, limiting assistance with cost-sharing only to recipients of cash assistance perpetuates welfare categories, policies, and state variations in the provision of medical assistance to low-income people, undermining the decoupling of medical assistance and welfare assistance embodied in the Medicaid expansions of the last decade. Income-based need, not categorical definitions, should be used to determine assistance with premiums and cost-sharing under any reform plan.

The combined impact of the premium structure, cost-sharing levels, and price

competition among health plans under the Clinton proposal may severely limit the choice of plans available in the alliance for low-income people. The cost-sharing structure effectively limits choice of plans for the poor to HMO-type plans with cost-sharing based on a per visit rather than percentage basis as under the fee-for-service option. If the fee-for-service plans with high cost-sharing, not the HMO-type plans, have the lowest premiums, the cost-sharing levels in the fee-for-service plan could financially preclude low-income people from selecting the lowest cost plan. These policies may also result in significant churning of the poor among plans if the poor move annually to stay in the lowest cost plan.

Finally, the role and responsibilities of the regional alliance with regard to coverage of the low-income population warrant further examination. Alliances will replace the Medicaid program's role in determining eligibility for subsidies, negotiating with and paying providers, and monitoring health plans. Plan selection and arrangements with essential providers to maintain community-based care networks for the poor as well as income determination for subsidies are all responsibilities to be assumed by the alliance. The ability of alliances to carry out many of these functions, particularly with regard to a low-income population, remains untested. Lessons from the Medicaid experience point to the importance of outreach and special initiatives to improve program participation and appropriate service use by the poor. Mounting such programs could be a challenge for most alliances, but may be necessary to promote access to care for the poor.

Conclusion

The current health care system provides inadequate coverage to the American people and leaves the poor particularly at risk of being uninsured and unable to afford care. Although Medicaid provides essential coverage for nearly 30 million low-income Americans, millions more are outside its reach. The financial stress facing Medicaid today in the states constrains the use of Medicaid as a vehicle to broaden coverage for low-income and vulnerable populations.

It is time to break the cycle of poor health, poverty, and inadequate insurance for America's poor. Adequate protection for health care will only be secured when all Americans are insured. Insurance coverage is critical to assure access to timely and appropriate care, not just emergency care or charity care when ill. Providing universal insurance is essential so that no American delays care or is denied care because they cannot pay. Affordable coverage for all and universal protection should be foremost on this nation's agenda so that the potential of universal coverage can become a reality for all Americans.

The President has provided both a blueprint for reform and a challenge to make it happen. The Kaiser Commission is committed to working with you in the Congress and with the Administration to bring fundamental reform to our health care system and improve coverage and access to care for all Americans, especially the poor and disadvantaged who have too often been left behind in our current health care system.

Thank you for this opportunity to appear before the Committee today.

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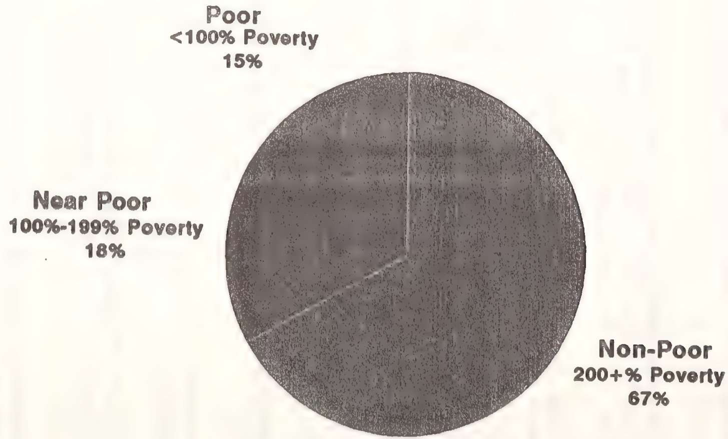
Figure 1 Distribution of the Nonelderly Population, by Poverty Level, 1991



Total = 220.8 Million Persons

Source: March Current Population Survey, 1992.

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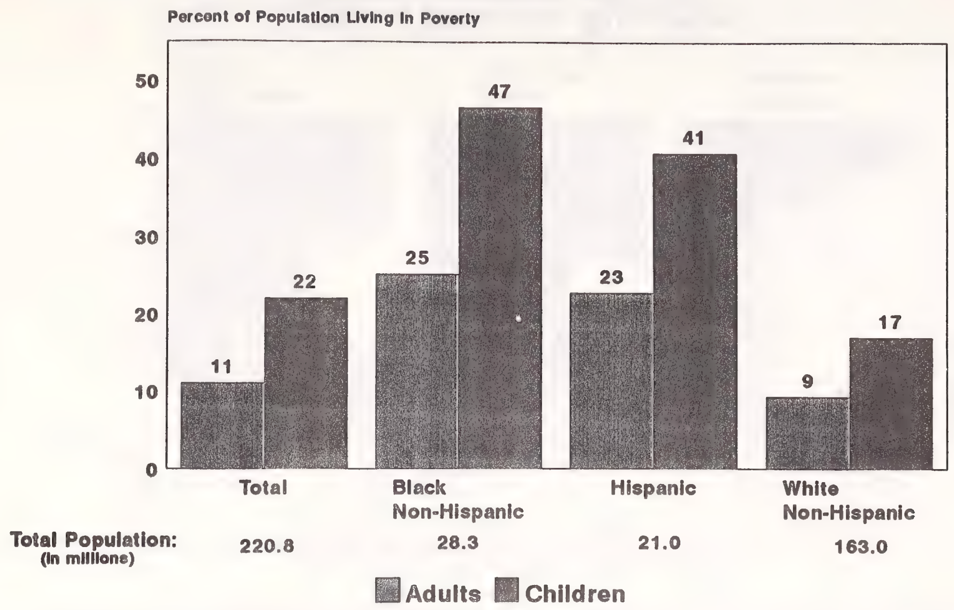
Figure 2 Poverty Rates, by Race/Ethnicity and Age, 1991



Source: March Current Population Survey, 1992.

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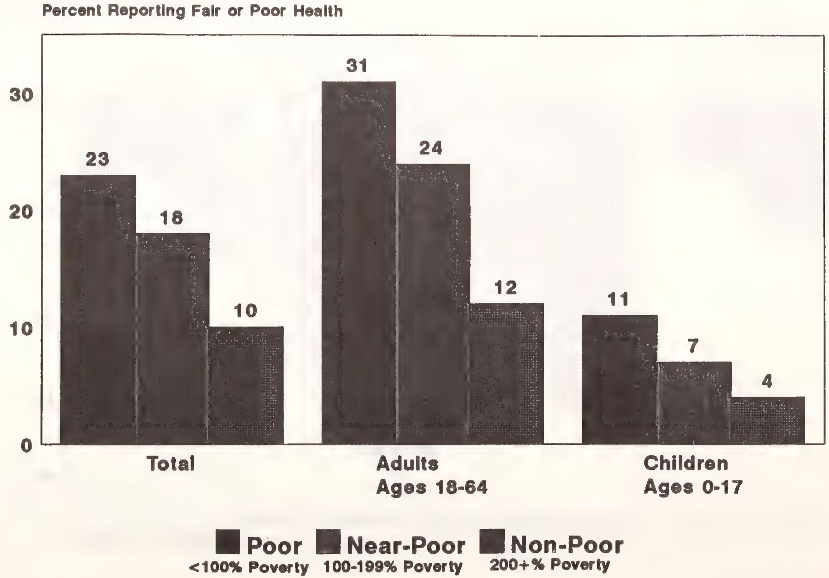
Figure 3 Percent of Population Reporting Fair or Poor Health, by Age and Poverty Level, 1987



Source: National Medical Expenditure Survey, 1987.

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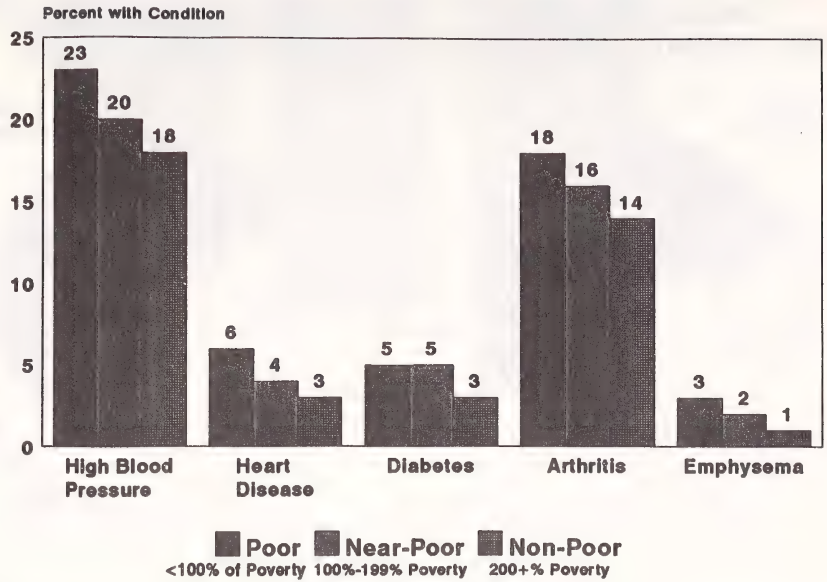
'gure 4 **Selected Chronic .lealth Conditions in Nonelderly Adults, by Poverty Level, 1987**



Source: National Medical Expenditure Survey, 1987.

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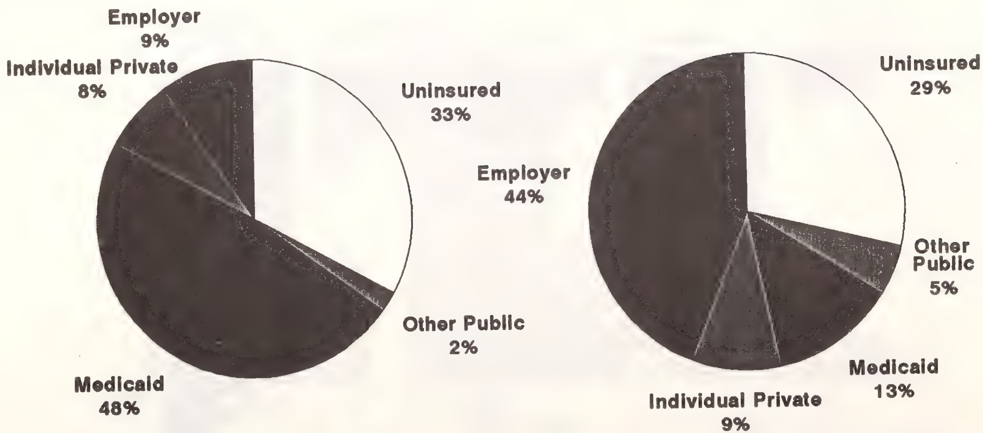
Figure 5 Distribution of the Low-Income Population, By Health Insurance, 1991



Poor (<100% Poverty)
Total = 32.1 Million

Near-Poor (100%-199% Poverty)
Total = 40.0 Million

Source: March Current Population Survey, 1992.

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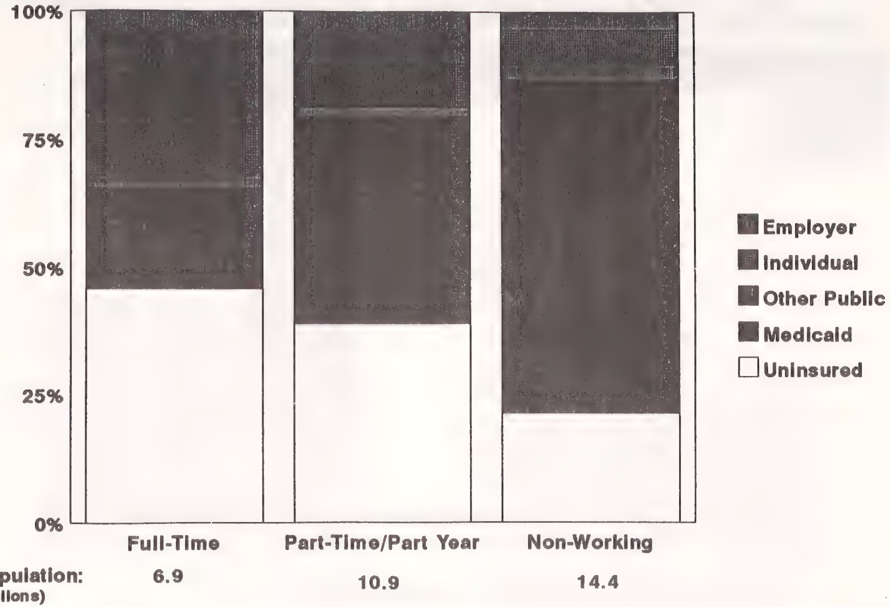
Figure 6 Health Insurance Coverage of the Poor Population, by Work Status, 1991



Source: March Current Population Survey, 1992.

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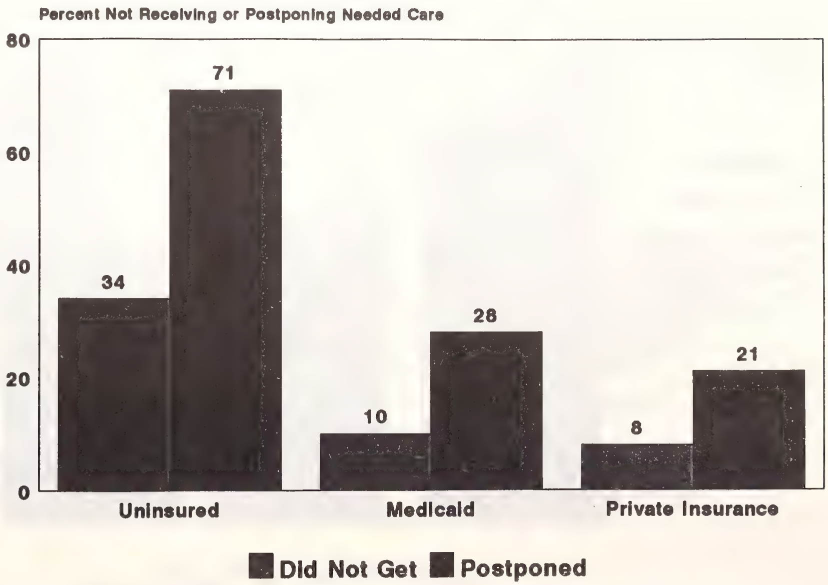
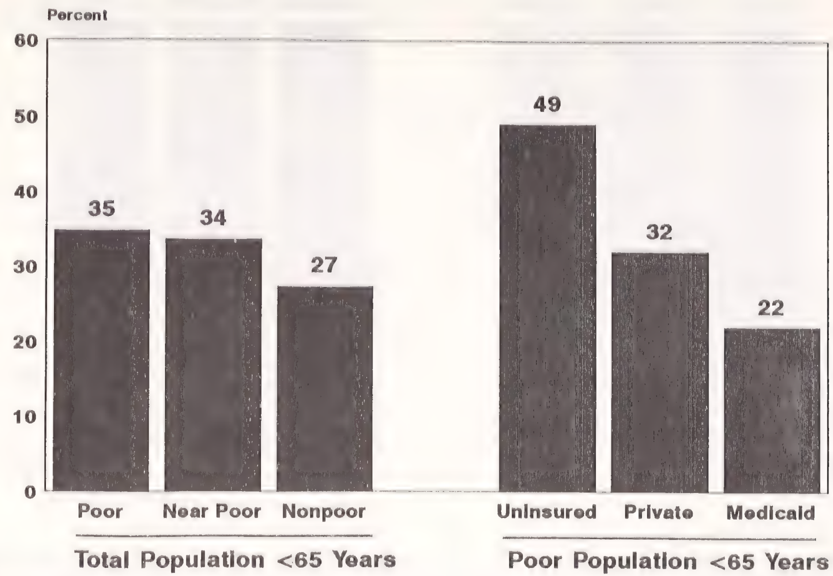
Figure 7 The Uninsured Are More Likely to Not Receive or to Postpone Needed Medical Care



Source: Kaiser/Commonwealth/Harris Poll, 1993.

Figure 8

Percent of the Nonelderly Population with No Physician Visit in Past Year, by Poverty Level and Insurance*, 1987



* Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

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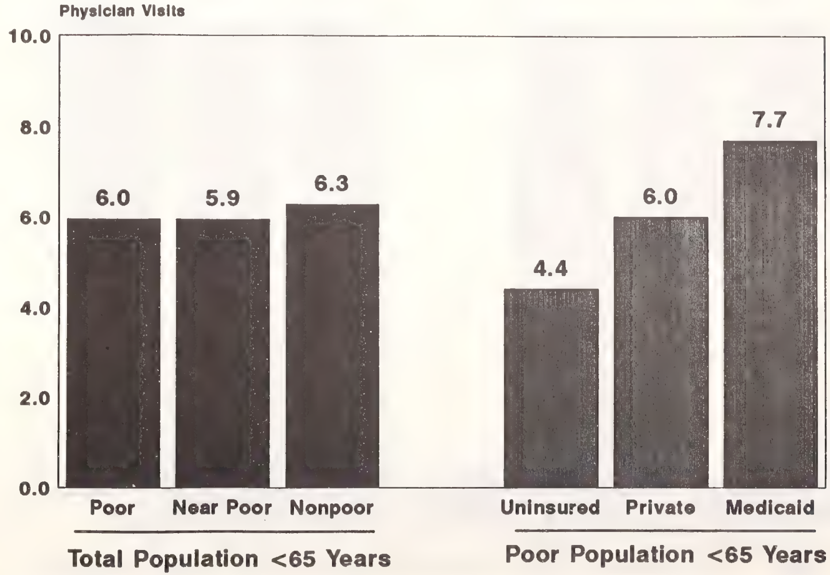
Figure 9
Mean Annual Physician Visits among the Nonelderly Population with at least One Visit, by Poverty Level and Insurance*, 1987



* Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

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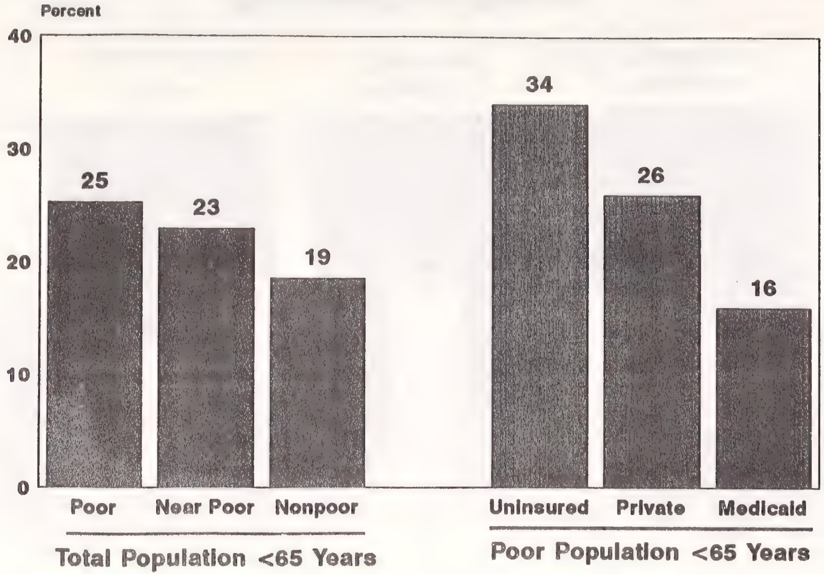
Figure 10 Percent of the Nonelderly Population with No Usual Source of Care, by Poverty Level and Insurance*, 1987



* Full-Year Coverage

Source: National Medical Expenditure Survey. 1987.

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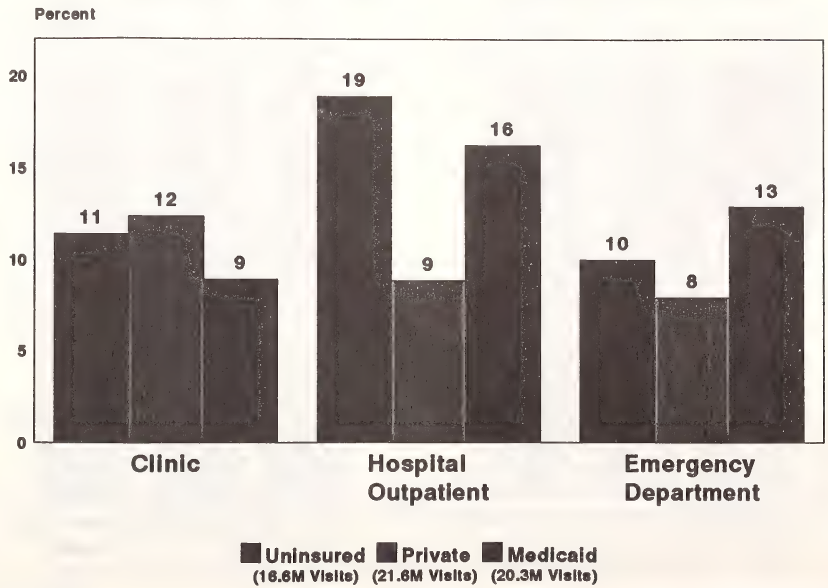
Figure 1. Percent of Physician Visits Obtained at Hospitals and Clinics by the Poor Population, by Insurance,* 1987



*Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

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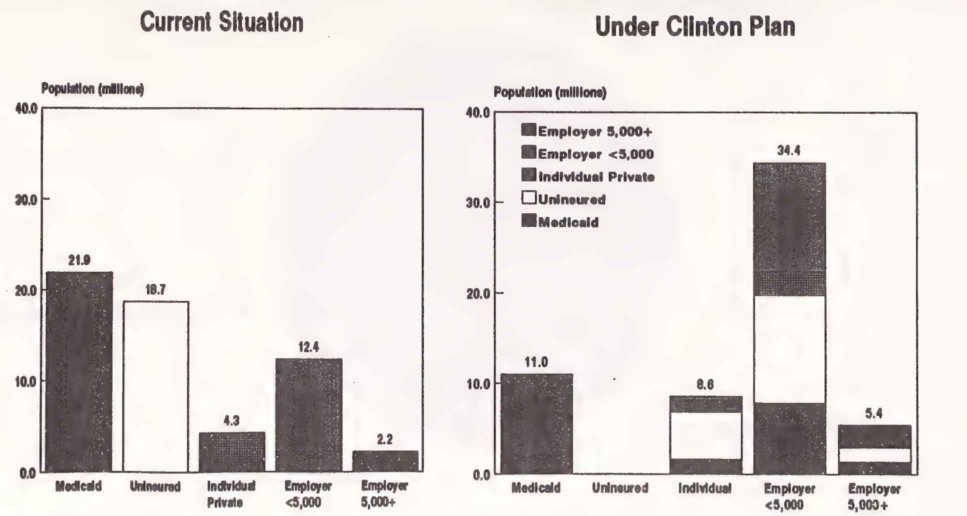
Figure ?

Distribution of Insurance of the Nonelderly Population with Incomes Below 150% of Poverty under Clinton Plan



Source: Urban Institute, 1993.

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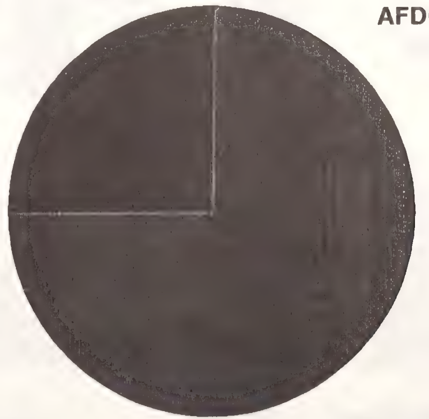
Figure 13 Distribution of the Nonelderly Medicaid Population by Welfare and Employment Status, 1991



Total = 23.4 Million in 1991

Source: Urban Institute, 1993.

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Mr. WAXMAN. The core of President Clinton's health care reform proposal is universal coverage for comprehensive benefits. Some argue that universal coverage is not necessary to assure adequate access to health care for uninsured low-income people, that all we need to do is put some additional resources into community health centers in those underserved areas that do not have sufficient or primary care capacity.

What is the view of the Kaiser Commission on this point? Is universal coverage necessary or would investment in primary care infrastructure be equally effective as a strategy for improving the access of uninsured low-income people to basic health care?

Ms. ROWLAND. The Kaiser Commission firmly believes the only way to reduce the inequities in access to health care service in this country is to provide an insurance card and access through the insurance system to all Americans. That does not mean we will not still need to have community health centers and other resource development activities in underserved areas to help supplement the availability of insurance, but without an insurance card, individuals, especially low-income individuals, do not have the ticket that provides you with entry into the American health care system.

We know from many, many studies that the uninsured use fewer health services. And even after adjusting for their health status, they do not have the same kind of access that other Americans have. We believe it is important to give them insurance coverage to build primary care and preventive care into their health care system and not just rely on emergency rooms for care when they are too sick to stay out of the system any longer.

Mr. WAXMAN. You estimated that about 6 million Medicaid eligibles who are not receiving cash assistance will not receive any assistance with cost sharing under the Clinton plan. Who are these noncash beneficiaries? Are they not largely the pregnant women and young children who we have made eligible for Medicaid over the past several years because their income is below 100 percent or 133 percent or 185 percent of poverty? And why doesn't the President's plan help these beneficiaries meet their cost sharing obligations? Will the lack of cost sharing subsidies affect the ability of those individuals to select the plan of their choice?

Ms. ROWLAND. As I stated earlier, we strongly feel that all individuals, on the basis of income, not on the basis of receipt of cash assistance, should be helped with the cost sharing levels under the President's plan. The people who are currently the noncash beneficiaries under Medicaid are in fact many of the pregnant women and children who your legislation helped get on the program, but also include many of the medically needy individuals who do not qualify for cash assistance but have large medical expenses that have made them eligible for services.

They are in fact often the sickest members of the Medicaid population and the highest utilizers, yet they will be the ones not covered by the cash assistance only policy. And we can provide you with the numbers for the record of how that breaks down and by type.

Mr. WAXMAN. We would like to receive that.

[The information follows:]

Medicaid Enrollment and Expenditures for Acute Care Services, by Eligibility Group, 1992

Population	Number of Beneficiaries[1]	Total Expenditures[2] (in thousands)	Acute Care Expenditures per Beneficiary
TOTAL	28,339,932	$46,438,567	$1,638
Cash Assistance	18,109,380	29,442,094	1,626
Adults	4,121,812	7,263,614	1,762
Children	8,996,321	7,641,642	850
Blind/Disabled	3,529,229	12,974,863	3,676
Elderly	1,462,018	1,561,975	1,069
Non-Cash Assistance	10,230,552	16,996,473	1,661
Pregnant Women	761,714	2,109,217	2,769
Children	6,042,953	6,420,576	1,062
Other Non-Elderly Adults	1,505,451	2,615,664	1,737
Blind/Disabled	743,476	4,054,587	5,454
Elderly	1,176,958	1,796,429	1,527

1. The number of Medicaid beneficiaries has been converted to full year equivalents to provide more accurate estimates of their health care expenditures.
2. Only expenditures for acute care services are included in these tabulations.

Source: Urban Institute analysis of the HCFA 2082.

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Mr. WAXMAN. You indicated in one of your charts that there is a shift in health insurance coverage for the poor, the near poor, under the Clinton plan. The chart indicates that the percentage of the nonelderly poor who are covered through employers, both those with less than 5,000 employees and those with more, will increase from 25 percent today to 67 percent under the Clinton plan.

Those figures are national averages. I assume these percentages will vary from State to State. Can you tell me what the corresponding estimates are for California and how do they compare to the national average? And could you comment on the implications of these State-by-State variations in employer coverage for the poor?

Ms. ROWLAND. The commission is currently working on developing a State-based analysis of the impact of the Clinton plan as well as some of the alternative plans being considered right now. In doing our analysis, that I presented the national numbers for today, we did take a look at New York, Florida, Texas, Michigan, and California to see what the impact would be in those States.

As you know, Medicaid coverage varies tremendously across the States, but so does the percent of the population that is uninsured. And it is the combination of both Medicaid coverage and the numbers of uninsured that create a greater employment effect in some States than others of this employer-based policy.

In California, the responsibility for Medicaid today covers about 45 percent of the population under 150 percent of poverty. That would drop to 21.1 percent under the Clinton proposal. The employer responsibilities in California are currently for about 18.5 percent of the population under 150 percent of poverty, and that would rise to 64 percent.

So that there would be—the California numbers are quite similar to some of the national numbers; the New York numbers and the Florida numbers, however, show you some of the dramatic differences. In Florida, employer responsibility goes from 18 percent to 70 percent, and in New York, employer responsibility only goes from 24 percent to 50 percent because of the relatively better coverage of the employed working poor in New York.

Mr. WAXMAN. Thank you very much.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

You have talked about the fact that utilization of health care is fundamentally an access issue. It is not a health status issue, and when you adjust for health status, you still find underutilization based on lack of access. I assume, therefore, that we can expect, as we expand access, greater utilization.

What impact do you expect insurance coverage to have on those with lower health status who are currently uninsured? Do you think that the administration has adequately estimated this increase in utilization and placed the subsidy caps high enough so that people are not denied care?

Ms. ROWLAND. I do think we see, when you provide coverage to individuals without insurance, greater access to the health care system and greater utilization of services. The estimates for how much that is range significantly across different studies, and I am not sure what estimates the administration is actually using in its calculations.

I would think that for some of the people currently on Medicaid who have greater assistance, especially the noncash population with cost sharing that we might actually see a decrease in access to care as a result of some of the cost sharing provisions of the President's plan. I think you would need to look at the balance between increased financial responsibility for some low-income people and increased access to care through insurance coverage.

Mr. GREENWOOD. You are advocating subsidies for the noncash recipients in your testimony. Do you have an estimate of the additional cost to providing these subsidies to low-income individuals?

Ms. ROWLAND. We do not have an estimate but we will be glad to work on that for the committee.

Mr. GREENWOOD. OK.

Yield back the balance of my time, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Mr. Wyden.

Mr. WYDEN. Ms. Rowland, if we were trying to estimate the cost of extending equivalent cost sharing assistance to those not eligible for cash aid, it seems that the costs of the President's proposed subsidy for cost sharing for low-income folks would have to rise considerably, maybe 25 percent. How much more health services do these folks use rather as compared to the cash aid recipients?

Ms. ROWLAND. Under our estimates, they are about twice as expensive today as the cash assistance recipients. So that they use much more, many more services. Part of that is because they tend to come into Medicaid for coverage at the point when they are ill and when they need services. Many of them are being enrolled today at the site of a hospital when they need care. So it is hard to know on balance what the actual cost would be of providing that to the general low-income population.

Mr. WYDEN. That really goes to my central concern, and I see it in today's system and I am concerned about it in the new system as well, is we are just not getting people early enough. In your statement you state the really eye-popping kind of figure, that 38 percent of the poor who have Medicaid coverage are either postponing the coverage or not getting services at all.

So what we have to do, both for the purpose of what we have been asking about today, those not on cash aid and the new system, is get the thoughts of you and others like you and what is it going to take to make it more likely to get people to come and use these services and particularly do it early on when we are much more likely to have a lower price tag.

Ms. ROWLAND. Well, certainly the administration's proposal does exempt some of the preventive services from cost sharing requirements, but it is also early attention through primary care that is extremely important for the low-income population, and that is where cost sharing does still have a role to play in the administration's proposal.

And I would look very closely at providing at least routine access to the medical care system without high cost sharing levels for the low-income population.

Mr. WYDEN. So if nothing else were done but to get rid of the cost sharing for primary care, we would come up with something,

in your view, that would hold costs down and be good public health policy as well?

Ms. ROWLAND. Although I do think, in a high cost sharing plan, 20 percent per day cost sharing on a day of hospital care is pretty onerous for most low-income people.

Mr. WYDEN. Good idea. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

In a State like New York, which has historically offered more comprehensive health care services than many other States, with the maintenance of effort provisions, are we not placing a tremendous burden on the States to continue the same level of service with just State funds?

Ms. ROWLAND. I think that one of the problems with any maintenance of effort that is built on the existing contributions to the Medicaid program does penalize a State that has been very generous and spent a lot of its resources on expanding Medicaid in the past and allows States that have been less generous to have less of a payment.

And I think that is why the administration has at least proposed in this legislation to do a commission that would look at how to more effectively realign those contributions rather than using historical trends.

Mr. TOWNS. I think that is very important. The current Medicaid matching formula is based purely on the comparison of State per capita income to the national average per capita income. The General Accounting Office has recommended that the Medicaid formula be changed to incorporate a measure of poverty. What are your views about the recommendations?

Ms. ROWLAND. I think it is always difficult to change any matching formula from what it is today, but I think clearly looking at all of the recommendations that have been made over the past few years by the GAO on the matching formula would be an important first step in getting a better and more effective matching formula into this plan for assistance with the low-income population.

Mr. TOWNS. Let me just ask you this as my final question. Given that Medicaid has been so underfinanced in the past, do you believe that projected savings in the reform package are realistic?

Ms. ROWLAND. I believe that to provide effective care and place the low-income population into the health care system for all Americans, we may well need to increase spending for the low-income population over the current levels under Medicaid.

I think once the disproportionate share payments are removed from the Medicaid capitation rates, we may see those rates as extremely low in contrast to the private sector rates in some States, maybe equal in others, and that is another area that the commission is currently doing some work on, looking at the capitation rates by State.

Mr. TOWNS. In closing, let me just say that I have some real concerns because when you start doing things on a national scale, the regions are so different, and what has happened in the past because it is so different, so those of us reside in New York, which is a high cost of living area, and also the fact our services up to

this point have been so comprehensive, we are extremely nervous about what the outcome of this will be.

Mr. Chairman, I yield back the balance of my time.

Mr. WAXMAN. Thank you, Mr. Towns.

Mr. Brown, sorry I passed you over. I didn't see you there before.

Mr. BROWN. I want to follow up on some things Mr. Wyden and Mr. Greenwood asked and also related to the questions I asked Mr. Vladeck earlier.

With the removal of the stigma of Medicaid for formerly Medicaid patients, if you will, and the guarantee the patients will receive care, that providers will be paid more, if you will, do you see a greater use of medical services by Medicaid patients?

Ms. ROWLAND. I don't see a greater use of services by the Medicaid population specifically. I do see a greater use of services by the uninsured population who are not today on Medicaid. But I think the Medicaid access levels will probably remain relatively the same.

The only group I am particularly concerned about are the noncash assistance recipients who may see a decreased use of services as a result of the cost sharing provisions.

Mr. BROWN. Will the nature of the services change? Will they be more likely or will they be less likely to go to emergency rooms, with some of the President's outreach programs; the public health education outreach measures?

Comment on that and tie it together, if you will. Will they use less expensive, more preventive care as a result of all of these, the stigma, if you will, being taken away; the incentives provided by the plan to get them into clinics and get them into child immunization and preventive care and all of that? Do you see much change there?

Ms. ROWLAND. The plan should help to move people more generally into the mainstream of health care plans and of health care providers. We have done some looking at the current use of emergency rooms by Medicaid patients. And, in fact, Medicaid patients do not use emergency rooms as much as everyone believes they do. Over 65 percent of all visits by Medicaid patients are to private doctors' offices, not to emergency rooms. A little less than that for the general population but still not out of line.

What we do see is greater use of emergency rooms by the uninsured population, and that is where one would hope to bring people into an earlier care system than emergency rooms. With the Medicaid population, I think moving toward managed care could help to reduce the use of some of the clinics and outpatient departments they use. But one has to also be cautious you do not disrupt some of the care patterns with private physicians that have already developed under Medicaid.

Mr. BROWN. Would you talk generally about your evaluation of the public health education and outreach programs in the health care plan: If we have gone far enough. If you would sort of critique those elements of it, and if you have other ideas to share with us about it.

Ms. ROWLAND. I think one of the most important things under the health plan in the way of education will be to begin to work with the low-income population to educate them on what their

choices of health care plans are and how to use those health care plans. In most of the Medicaid managed care demonstrations that have gone on, education of the consumer population in how to execute their choices and how to negotiate the health care system has proven very important to providing them with reasonable access to care.

And I would urge, in fact, there be more public education and more assistance to the low-income population with their selection of health plans and then with how to use the health plan effectively both at the health plan level and at the alliance level if that is where the low-income population is going to be selecting their health care plans.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. GREENWOOD. Mr. Chairman, may I reclaim 1 minute that I yielded back?

Mr. WAXMAN. Certainly.

Mr. GREENWOOD. I want to clarify one point. This issue of those who enter the system that are not covered by Medicaid, people enter the system, cannot meet their medical bills, and then become Medicaid eligible. This is a very common phenomenon, as far as I have been able to experience. It is the waitress or the gasoline station pumper who does not have health care and has a ruptured appendix, a fall, or an accident. They end up in the hospital and have no way of paying for their health care, and so a social worker from the hospital comes up and makes them Medicaid eligible and then Medicaid pays the bill.

We are looking at this population and are saying they are more expensive because they are not getting their primary health care. They are just entering the system because all of a sudden they have a hospital bill. Isn't the latter case more costly to the system?

Ms. ROWLAND. It is, in part, the factor that drives it, but, more importantly, a lot of the individuals on Medicaid today are sicker generally than the rest of the population. Medicaid covers severely disabled children and many of the individuals who have very high out-of-pocket expenses because of their chronic illness and their inability to work and to be covered through the workplace.

So that it is not just the point-of-service contact but it is also the fact that consistently the Medicaid population takes care of the sickest and most vulnerable of our population.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Dr. Rowland, we very much appreciate your testimony. Thank you.

Ms. ROWLAND. Thank you.

Mr. WAXMAN. We are going to break now until 1:30 p.m. and we will resume the hearing in this room at 1:30 p.m.

[Whereupon, at 12:20 p.m., the subcommittee recessed, to reconvene at 1:30 p.m., this same day.]

AFTER RECESS

Mr. WAXMAN. The meeting of the subcommittee will come back to order.

Our next witnesses include representatives of the beneficiaries and physicians who serve them. Dr. Gary Dennis is a member of the Board of Trustees of the National Medical Association; Stan Dorn is Managing Attorney of the Washington office of the National Health Law Program; Gregg Haifley is a Senior Health Associate at the Children's Defense Fund; and Ann Kolker is Public Policy Director for Health and Reproductive Rights at the National Women's Law Center.

I want to welcome you all to our hearing today. Your prepared statements will be in the record in full. What we would like to ask you to do is limit the oral presentation to no more than 5 minutes.

Mr. Dennis, why don't we start with you?

STATEMENTS OF GARY C. DENNIS, MEMBER, BOARD OF TRUSTEES, NATIONAL MEDICAL ASSOCIATION; STAN DORN, ATTORNEY, NATIONAL HEALTH LAW PROGRAM; GREGG HAIFLEY, SENIOR HEALTH ASSOCIATE, CHILDREN'S DEFENSE FUND; AND ANN KOLKER, DIRECTOR, PUBLIC POLICY/HEALTH AND REPRODUCTIVE RIGHTS, NATIONAL WOMEN'S LAW CENTER

Mr. DENNIS. I am Gary Dennis, I am a neurosurgeon who practices in the Washington area. I have a lot of direct experience with treating Medicaid and uninsured patients. I am also a member of the Board of Trustees of the National Medical Association.

The National Medical Association is the oldest African-American professional association in the United States. NMA, in fact, will celebrate its centennial in 1995 and has a proud history of advocacy for African-American and other minority groups regardless of socioeconomic status.

In fact, we are one of the few physician organizations that supported the enactment of Medicaid and Medicare.

Of course, we applaud the President's leadership in regards to national health reform, and we hope that we can work with Congress to help iron out some of the more testy issues.

As far as Medicaid and the uninsured are concerned, of course the number of uninsured are astronomical, 31 to 36 million, with different ethnic groups being disproportionately affected with much higher percentages of uninsured minorities.

Also, Medicaid, although developed for the poor, has only ever covered 38 to 40 percent of those in poverty, which means you do not have a good idea of exactly how much it costs to serve that population. Even with that, the cost we have provided to Medicaid has bankrupted States and hospitals and, of course, it really has extended our national budgetary requirements, especially since one-half of that goes toward long-term care.

Now, such data certainly indicates that Medicaid needs reforming and the NMA offers its reviews today on Medicaid and low income patients. NMA applauds the President's commitment to universal coverage and we are firmly behind that, and we strongly support making health care available without consideration of preexisting health conditions.

We are also pleased that the AFDC and SSI recipients will not lose any currently mandated benefits and that special provisions are made to make sure all medically necessary items and some

non-medically necessary items, such as transportation and child care, will be provided.

However, greater emphasis should be placed on these as well as provision of services for children, and especially children with special needs, which should be provided in a more sensitive threshold for items such as hearing aids and eyeglasses.

The NMA applauds the availability of grants and contracts for those serving the most needy and medically underserved. We are concerned about the 5-year limitation, however, on participation by essential community providers, and we feel that there should not be that kind of limitation.

And we also feel public hospitals and clinics should automatically be certified as essential community providers since they are actually providing the essential community care today.

We are concerned that many low income families are expected to pay significant copayments. Currently all services are received with no payment at the point of service, and we feel that will be a significant burden for many families. We are concerned that the low cost/high cost sharing schedules actually translate into a two-tier system which is similar to what we have now and, in fact, we are concerned that the poorest patients may be funneled into a low cost sharing system which is overloaded and has declining quality.

We are concerned that decisions made about income verification and premium discounts will be made by a regional alliance, but the alliances do not have representation, especially from the low income consumers and ethnic minorities, and also there is not representation of health care providers at the alliance level.

We feel that we definitely need health care providers represented to ensure quality of care.

We are concerned that the composition of the Medicaid commission is limited to Federal and State government representatives. This commission should be ethnically and culturally representative of the U.S. population. We strongly oppose Medicare and Medicaid spending reductions. We support increased taxes on things like alcohol and firearms, and increased tort reform measures to further finance health care rather than taking money from existing Medicare and Medicaid budgets.

We also are concerned about the sliding scale for adjustment of premium discounts as it applies to family adjusted income above 100 percent of the poverty level. In fact, we feel this is probably a very low threshold.

We are concerned that provisions are not made for a mechanism for adults who may have uncovered medically necessary benefits. There should be a mechanism for that to be granted.

NMA also urges a provision of grants for States for educational services which are culturally sensitive and culturally competent, which includes the use of organizations which are multidisciplinary and community based and charged with educating the newly insured with an emphasis on how to access the new health care delivery system because we feel that utilization of the system is definitely going to help to control the cost of that system.

NMA recognizes the accomplishments of Medicaid. It has served a broad based section of American people and its adoption coincides with significant improvements in the health status of Americans.

We recognize the program's importance to the financial well-being, if not the survival of many major teaching hospitals and the majority of nursing homes in this country.

Mr. Chairman, members of the committee, the NMA is committed to working with you in formulating health care policy in America. This policy must benefit Medicaid recipients and persons of low income. That must be our collective obligation.

Thank you for allowing the NMA to speak on these issues.

Mr. WAXMAN. Thank you very much Dr. Dennis.

[Testimony resumes on p. 624.]

[The prepared statement of Dr. Dennis follows:]

STATEMENT OF GARY C. DENNIS,

NATIONAL MEDICAL ASSOCIATION

CHAIRMAN WAXMAN, MEMBERS OF THE COMMITTEE, I AM PLEASED TO JOIN YOU TODAY ON BEHALF OF THE NATIONAL MEDICAL ASSOCIATION (NMA). I AM DR. GARY C. DENNIS, TRUSTEE OF THE NATIONAL MEDICAL ASSOCIATION AND VICE CHAIR OF THE BOARD'S COMMITTEE ON HEALTH POLICY AND RESOLUTIONS. I AM CHIEF OF NEUROSURGERY AND PRESIDENT OF THE MEDICAL STAFF AT HOWARD UNIVERSITY HOSPITAL WHICH HAS SERVED WASHINGTON'S INDIGENT COMMUNITY FOR OVER A CENTURY.

AS A NEUROSURGEON ON THE STAFF OF D.C. GENERAL HOSPITAL, I AM ASSOCIATED WITH YET ANOTHER INSTITUTION THAT SERVES PRIMARILY MEDICAID AND UNINSURED PATIENTS.

MY EXPERIENCE WITH MEDICAID ALSO EXTENDS TO THE POLICY LEVEL. I HAVE BEEN A MEMBER OF THE PRACTICING PHYSICIANS ADVISORY COUNCIL FOR THE HEALTH CARE FINANCING ADMINISTRATION FOR TWO YEARS. IN MAY OF THIS YEAR I WAS APPOINTED TO THE BOARD OF HEALTH OF THE DISTRICT OF COLUMBIA.

I AM A NATIVE WASHINGTONIAN, FULLY COMMITTED TO PROVIDING ACCESS TO QUALITY HEALTH CARE FOR ALL AMERICANS REGARDLESS OF THEIR SOCIOECONOMIC STATUS, RACE OR OTHER CONSIDERATIONS.

MY TESTIMONY TODAY IS ON BEHALF OF THE NATIONAL MEDICAL ASSOCIATION , THE OLDEST AFRICAN AMERICAN PROFESSIONAL ASSOCIATION IN THE UNITED STATES. NMA WILL CELEBRATE ITS CENTENNIAL IN 1995. WE HAVE A PROUD HISTORY OF ADVOCACY FOR AFRICAN AMERICAN AND OTHER MINORITY GROUPS REGARDLESS OF SOCIOECONOMIC STATUS. WE WERE IN FACT ONE OF THE FEW IF NOT THE ONLY PHYSICIAN'S ORGANIZATION THAT SUPPORTED THE ENACTMENT OF MEDICAID AND MEDICARE IN THE 1960S AND WE ARE COMMITTED TO HEALTH CARE REFORM TODAY. WE APPLAUD THE PRESIDENT'S LEADERSHIP IN THIS REGARD. WE ALSO INTEND TO WORK WITH THE CONGRESS IN PRODUCING HEALTH CARE REFORM LEGISLATION THAT WILL BENEFIT MEDICAID RECIPIENTS IN EQUAL MEASURE WITH OTHERS IN THE UNITED STATES.

MEDICAID AND THE UNINSURED

ACCESS TO ACUTE CARE FOR AMERICANS WHO LACK COVERAGE FOR THE COST OF THAT CARE HAS BEEN A PROBLEM FOR MOST AMERICANS AT ONE TIME. AFTER THE INTRODUCTION OF PRIVATE INSURANCE EARLY IN THE 20TH CENTURY, IT BECAME A PROBLEM MORE OF SPECIFIC GROUPS, NOTABLY THE ELDERLY AND THE POOR. WITH THE PASSAGE OF MEDICAID AND MEDICARE IN 1965, IT WAS THOUGHT THE ISSUE WAS LARGELY RESOLVED.

THE UNINSURED, HOWEVER, LIKE THE PROVERBIAL POOR, SEEM ALWAYS TO BE WITH US. IN FACT, THEIR NUMBERS HAVE GROWN SIGNIFICANTLY IN THE LAST 15 YEARS. PROPOSALS ARE PLENTIFUL, YET CONSENSUS ON HOW TO ATTACK THE PROBLEM IS ELUSIVE.

MOST ESTIMATE THAT 31 TO 36 MILLION AMERICANS LACK PUBLIC OR PRIVATE COVERAGE. THE 1987 NATIONAL MEDICAL EXPENDITURE SURVEY FOUND THAT 47.8 MILLION PEOPLE LACKED INSURANCE FOR ALL OR PART OF 1987, WITH BETWEEN 34 AND 36 MILLION UNINSURED ON ANY GIVEN DAY AND 24.5 MILLION UNINSURED THROUGHOUT THAT YEAR.

RACIAL AND ETHNIC DIFFERENCES AFFECT RATES OF COVERAGE. OF NON-HISPANIC WHITES, 18.6 % WERE UNINSURED FOR ALL OR PART OF 1987, AS WERE 29.8% OF AFRICAN AMERICANS AND 41.4 % OF HISPANIC AMERICANS. MEN ARE SLIGHTLY MORE LIKELY TO BE UNINSURED THAN WOMEN; 23.8% OF MEN WERE UNINSURED FOR AT LEAST PART OF 1987 AS OPPOSED TO 21% OF WOMEN. THIS UNDOUBTEDLY REFLECTS THE FACT THAT VIRTUALLY ALL MEN, REGARDLESS OF THEIR INCOME, ARE EXCLUDED FROM ELIGIBILITY FOR MEDICAID.

THE PROPORTION OF UNINSURED VARIES BY STATE, DEPENDING ON SEVERAL FACTORS, INCLUDING THE LEVEL OF MEDICAID COVERAGE IN THE STATE, THE DEMOGRAPHICS OF THE POPULATION, INSURANCE PRACTICES, OVERALL INCOME, THE NATURE OF EMPLOYMENT, AND STATE HEALTH POLICY. THE NATIONAL MEDICAL EXPENDITURE SURVEY FOUND LACK OF INSURANCE HIGHEST IN THE SOUTH (27.4% OF THE POPULATION WERE UNINSURED AT LEAST PART OF THE YEAR) AND WEST (27.2%) AND LOWEST IN THE MIDWEST (16.7%) AND NORTHEAST (15.7%). THE EMPLOYEE BENEFIT RESEARCH INSTITUTE FOUND THAT LACK OF COVERAGE RANGED FROM LESS THAN 10% IN MASSACHUSETTS, PENNSYLVANIA, MICHIGAN, WISCONSIN, AND IOWA TO MORE THAN 25% IN LOUISIANA, TEXAS, AND NEW MEXICO. HOW COULD SUCH A LARGE NUMBER OF AMERICANS COME TO BE AT RISK, THROUGH LACK OF COVERAGE OR LACK OF ACCESS OR BOTH, IS A MAJOR QUESTION.

MEDICAID IS A STATE-LEVEL PROGRAM, WITH EACH STATE DEFINING INCOME LEVELS AND OTHER STANDARDS OF ELIGIBILITY AND THE FEDERAL GOVERNMENT SUBSIDIZING A CERTAIN PORTION OF EXPENSES, DEPENDING ON THE STATE'S OVERALL WEALTH.

AS A RESULT OF THE RATHER TANGLED PATH IT HAS TRAVELED, MEDICAID NEVER COVERED THE ENTIRE POVERTY POPULATION AND WAS ESTIMATED TO COVER ONLY 38.7% OF THAT GROUP IN 1983. BY 1989, IT WAS ESTIMATED THAT ONLY 40% OF THE POVERTY POPULATION WAS COVERED BY THE PROGRAM. ALTHOUGH CONGRESSIONAL MANDATES MAY BOOST THAT FIGURE SOMEWHAT, THE MAJORITY OF THE POOR REMAIN UNPROTECTED BY THE PROGRAM THAT WAS DESIGNED TO COVER THEM.

THE NEED TO REVAMP MEDICAID: BACKGROUND AND CURRENT PROBLEM

MEDICAID IS A PERENNIAL PROBLEM. IT WAS SET UP 26 YEARS AGO TO PROVIDE THE POOR WITH HEALTH CARE, THIS JOINT FEDERAL-STATE HEALTH INSURANCE PROGRAM IS NOW EXPERIENCING SEVERE FINANCIAL DIFFICULTIES. THE NUMBER OF MEDICAID RECIPIENTS HAS GROWN MODESTLY, BUT EXPENDITURES, IN CONTRAST, HAVE INCREASED DRAMATICALLY. BETWEEN 1980 AND 1989, THE NUMBER OF MEDICAID RECIPIENTS INCREASED BY 9%, WHILE EXPENDITURES ROSE AN ASTOUNDING 123%. THE MEDICAID PROGRAM HAS ALSO TAKEN A CORRESPONDINGLY BIGGER BITE OUT OF STATE BUDGETS: 9% IN 1980, BUT 14% IN 1990.

AS A SIGN OF HOW SERIOUS THE FUNDING PROBLEM IS, STATE GOVERNMENTS AND HOSPITALS HAVE BECOME ADVERSARIES. STATES CUT PAYMENTS, HOSPITALS FIGHT BACK IN THE COURTS.

THE PRIMARY REASON MEDICAID IS IN A CRISIS IS THAT IT DEDICATES ALMOST HALF OF ITS PAYMENTS TO LONG-TERM CARE. IN 1986, FOR EXAMPLE, 45% OF TOTAL MEDICAID SPENDING PROVIDED ONLY 7% OF ITS ELIGIBLE POPULATION WITH SERVICES IN NURSING FACILITIES OR INSTITUTES FOR THE

MENTALLY RETARDED OR MENTALLY ILL. AS THE POPULATION AGES, THE PROBLEM WILL ONLY GROW WORSE.

THESE STATISTICS POINT TO THE CRITICAL NEED FOR A RANGE OF TREATMENT, PREVENTION, FAMILY SUPPORT, HOME AND COMMUNITY-BASED SERVICES FOR THE MEDICAID AND LOW INCOME POPULATION.

RACE AND MEDICAID UTILIZATION

ACCORDING TO A REPORT AUTHORED BY MARCIA WADE OF THE URBAN INSTITUTE IN JULY 1992, WHITE MEDICAID ENROLLEES HAVE GREATER ACCESS TO SERVICES THAN NON-WHITE ENROLLEES. THE EXCEPTIONS ARE CLINIC VISITS FOR ADULTS AND CHILDREN AND HOSPITAL OUTPATIENT VISITS FOR ADULTS. BEING WHITE IS SIGNIFICANTLY AND POSITIVELY RELATED TO MEDICAL OFFICE, CLINIC AND HOSPITAL OUTPATIENT DEPARTMENT VISITS PER RECIPIENT AND TO THE USE OF LABORATORY SERVICES AND PRESCRIPTION DRUGS. IN CONTRAST, FOR WHITE ADULTS AND CHILDREN, THE NUMBER OF INPATIENT DAYS AND THE NUMBER OF INPATIENT SURGICAL PROCEDURES PER RECIPIENT ARE LESS THAN FOR NON-WHITE ENROLLEES.

SUCH DATA CERTAINLY INDICATE THAT MEDICAID NEEDS REFORMING. WE ARE PREPARED TO ADDRESS SOME OF THESE REFORM ISSUES IN TODAY'S

TESTIMONY, AND REQUEST THE OPPORTUNITY TO SHARE OTHER VIEWS IN THE FUTURE.

NMA POSITIONS ON THE HEALTH SECURITY ACT

NMA OFFERS THE FOLLOWING OBSERVATIONS WITH REGARDS TO THE HEALTH SECURITY ACT:

1. NMA APPLAUDS THE PRESIDENT'S COMMITMENT TO UNIVERSAL COVERAGE. WE ALSO STRONGLY SUPPORT MAKING HEALTH CARE COVERAGE AVAILABLE WITHOUT CONSIDERATION OF PREEXISTING HEALTH CONDITIONS.

2. WE ARE PLEASED THAT AFDC/SSI RECIPIENTS WILL NOT LOSE ANY CURRENTLY MANDATED BENEFITS AND THAT SPECIAL PROVISIONS ARE MADE FOR THE PROVISION OF ALL MEDICALLY NECESSARY ITEMS AND SERVICES FOR CHILDREN NOT INCLUDED IN THE COMPREHENSIVE BENEFIT PACKAGE. WE ARE EQUALLY PLEASED THAT NO PREMIUMS ARE REQUIRED FOR AFDC/SSI FAMILIES.

3. THE NMA APPLAUDS THE AVAILABILITY OF GRANTS AND CONTRACTS FOR THOSE SERVING THE MOST NEEDY AND MEDICALLY UNDERSERVED. WE ARE CONCERNED ABOUT THE FIVE YEAR LIMITATION ON PARTICIPATION BY ESSENTIAL COMMUNITY PROVIDERS AND URGE THAT IT BE STRICKEN IN LIGHT OF THE IMPORTANT ROLE THIS GROUP WOULD PLAY IN SERVING MEDICAID AND LOW INCOME RECIPIENTS.

4. WE ARE CONCERNED THAT AFDC/SSI FAMILIES ARE EXPECTED TO PAY 20% OF ALL AMOUNTS LISTED IN THE COPAYMENT SCHEDULE. CURRENTLY ALL SERVICES ARE RECEIVED WITH NO PAYMENT AT THE POINT OF SERVICE. PROVISIONS MUST BE MADE TO PHASE IN THIS REQUIREMENT AND IN CASES WHERE A COPAYMENT WOULD PREVENT THE PROVISION OF NECESSARY CARE, THE PAYMENT PROVISION SHOULD BE ELIMINATED.

5. WE ARE CONCERNED THAT LOW COST/HIGH COST SHARING SCHEDULES ACTUALLY TRANSLATE INTO A TWO TIER SYSTEM. AS WITH OUR CURRENT SYSTEM, THOSE WITH THE ABILITY TO PAY WILL RECEIVE THE GREATER CARE. WHEN LARGE NUMBERS OF INDIGENT PATIENTS, WHOSE HEALTH STATUS IS THE POOREST, ARE FUNNELLED INTO THE LOW COST SHARING PLAN, SYSTEM OVERLOAD AND DECLINING QUALITY OF CARE WILL RESULT.

6. WE ARE CONCERNED THAT DECISIONS MADE ABOUT INCOME VERIFICATION AND PREMIUM DISCOUNTS WILL BE MADE BY THE REGIONAL ALLIANCE. YET, THERE ARE NO PROVISIONS FOR PROPORTIONAL REPRESENTATION OF ETHNIC MINORITIES OR THE REPRESENTATION OF CONSUMERS (PARTICULARLY LOW INCOME CONSUMERS) AT THAT LEVEL.

NMA OPPOSES THE LIMITATION ON MEMBERSHIP OF THE BOARD OF DIRECTORS OF REGIONAL ALLIANCES, WHICH AS CURRENTLY WRITTEN WOULD BE COMPOSED OF EMPLOYERS WHOSE EMPLOYEES PURCHASE HEALTH COVERAGE THROUGH THE ALLIANCE AND MEMBERS WHO REPRESENT INDIVIDUALS WHO PURCHASE SUCH COVERAGE. HEALTH CARE PROVIDERS, WHO ARE IN THE BEST POSITION TO ADVOCATE FOR THE HEALTH NEEDS OF MEDICAID RECIPIENTS, ARE SPECIFICALLY PREVENTED FROM PARTICIPATING ON THESE BOARDS.

7. WE ARE CONCERNED THAT THE COMPOSITION OF THE MEDICAID COMMISSION IS LIMITED TO FEDERAL AND STATE GOVERNMENT REPRESENTATIVES. THIS COMMISSION SHOULD BE ETHNICALLY AND CULTURALLY REPRESENTATIVE OF THE U.S. POPULATION, AND INCLUDE CULTURALLY SENSITIVE AND CULTURALLY COMPETENT PROVIDERS AND OTHERS PERSONS WHO CAN REPRESENT THE INTERESTS OF MEDICAID RECIPIENTS.

8. WE ARE CONCERNED ABOUT MEDICAID FINANCING AND STRONGLY OPPOSE MEDICAID AND MEDICARE SPENDING REDUCTIONS. MEDICAID FUNDS MUST NOT BE USED TO FINANCE HEALTH CARE REFORM, INSTEAD THE

PROGRAM MUST BE RESTRUCTURED AS TO PROVIDE ADEQUATE COVERAGE FOR THESE RECIPIENTS. NMA HAS ENDORSED TAXES ON ALCOHOL AND FIREARMS AS FAIR AND APPROPRIATE REVENUE SOURCES.

9. WE ARE CONCERNED THAT THE SLIDING SCALE FOR ADJUSTMENT OF PREMIUM DISCOUNTS, APPLIES TO FAMILY ADJUSTED INCOME ABOVE 150 PERCENT OF THE POVERTY LEVEL. IN FACT, THERE IS A GRADUATED PHASE OUT OF THE DISCOUNT UP TO 150 PERCENT OF THE POVERTY LEVEL. THIS IS A VERY LOW THRESHOLD.

10. WE ARE CONCERNED THAT PROVISIONS ARE NOT MADE FOR A MECHANISM FOR ADULTS (CHILDREN ARE COVERED) WHEREBY UNCOVERED, MEDICALLY NECESSARY BENEFITS MAY BE GRANTED.

11. WE ARE CONCERNED THAT CONVENIENT HOSPITAL AND HEALTH PROFESSIONALS ARE CURRENTLY NOT AUTOMATICALLY CERTIFIED AS ESSENTIAL COMMUNITY PROVIDERS. PUBLIC HOSPITALS AND CLINICS ARE THE ESSENTIAL COMMUNITY PROVIDERS FOR MEDICAID RECIPIENTS RIGHT NOW.

12. NMA URGES THE PROVISION OF GRANTS TO STATES FOR EDUCATIONAL SERVICES WHICH ARE CULTURALLY SENSITIVE AND CULTURALLY COMPETENT. ORGANIZATIONS WHICH ARE MULTI-DISCIPLINARY AND

COMMUNITY-BASED SHOULD BE CHARGED WITH EDUCATING THE NEWLY INSURED ON ACCESSING THE HEALTH CARE DELIVERY SYSTEM.

THE NATIONAL MEDICAL ASSOCIATION RECOGNIZES THE NECESSITY TO GAIN CONTROL OF THE HEALTH CARE CRISIS IN THIS COUNTRY. WHILE REVAMPING THE MEDICAID PROGRAM, ONE WHICH PAYS FOR MEDICAL CARE FOR MANY OF THE NATION'S POOR, WE MUST REMAIN COGNIZANT OF THE ACCOMPLISHMENTS OF THIS PROGRAM IN PROVIDING ACCESS TO MEDICAL CARE FOR THE POOR. AVAILABLE EVIDENCE SUGGESTS THAT MEDICAID HAS BEEN FAR MORE VALUABLE THAN IS COMMONLY REALIZED. IT HAS SERVED A BROAD CROSS-SECTION OF THE AMERICAN PEOPLE AND ITS ADOPTION COINCIDES WITH SIGNIFICANT IMPROVEMENTS IN THE HEALTH STATUS OF AMERICANS. NOT WIDELY RECOGNIZED IS THE PROGRAM'S IMPORTANCE TO THE FINANCIAL WELL-BEING IF NOT THE VERY SURVIVAL OF MANY MAJOR TEACHING HOSPITALS AND THE MAJORITY OF NURSING HOMES IN THIS COUNTRY.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, THE NATIONAL MEDICAL ASSOCIATION IS COMMITTED TO WORK WITH GOVERNMENT DECISION-MAKERS, AND LEADERS OF PRIVATE AND PROFESSIONAL ORGANIZATIONS, IN FORMULATING HEALTH CARE POLICY IN THIS COUNTRY. THAT POLICY MUST

BENEFIT MEDICAID RECIPIENTS AND PERSONS OF LOW INCOME. THAT MUST BE OUR COLLECTIVE OBLIGATION.

THANK YOU ALLOWING THE NATIONAL MEDICAL ASSOCIATION TO HELP ENSURE THAT THE SPECIAL NEEDS OF UNSERVED, UNDERSERVED, AND UNDERREPRESENTED MEMBERS OF OUR POPULATION ARE ADDRESSED BY HEALTH REFORM INITIATIVES.

STATEMENT OF STAN DORN

Mr. WAXMAN. Mr. Dorn?

Mr. DORN. Chairman Waxman, good afternoon. It is an honor to be here today. The National Health Law Program is the legal services national backup center focusing on health service. We work with legal services programs around the country that try to get their clients essential health care, and Mr. Chairman, no one in the Congress has done more than you over the years to make sure that legal services clients get health care.

Millions of our clients today would not have health care but for your efforts, and I would be remiss if I did not take this opportunity to thank you exceedingly and to express our commitment to work with you and your office to make sure that health care reform achieves its promise with respect to low-income people.

It is quite an honor to be here and that promise is very great. We believe that the administration's bill provides a solid foundation upon which the Congress can build, and this afternoon I would like to talk about a few of the positive features of the administration's bill we need to hold on to in the Congress as well as some of the areas where improvement is needed.

The first positive area of the bill obviously is universal coverage. There are millions of low-income people who suffer greatly for lack of health insurance and that problem would be solved to a great extent under the administration's bill, nearly universal coverage.

The second positive feature is that the bill tries to mainstream low-income people into the same health plans that serve their middle class neighbors, notably the blended rate where Medicaid funds and private insurance funds are combined at the alliance and paid out to health plans at the same basic amount for all consumers is critical.

It would overcome what we see as the principal access problem facing Medicaid beneficiaries today, their inability frequently to find physicians willing to accept the minimal reimbursement rates that Medicaid offers. A critical feature we need to hang onto.

A second related feature is that the bill permits low-income people to enroll in any plan up to the regional average and under some circumstances above that. One of the best guarantors of quality is if low-income people can be in the same plans that serve everyone else.

On the other side of the ledger, there are some areas where improvement is needed, and one has already received much discussion today. The central role of cash assistance in defining the level of low income assistance that people receive. It runs directly contrary to the positive important efforts of this subcommittee over the years to disentangle cash assistance from receipts of help for low income folks.

People who get—those who do not get cash assistance will have to pay premiums on a sliding scale, which means they will go without other necessities of life. Now, a quarter of beneficiaries reports they cannot buy food, clothing, cannot pay their rent increase. Copays and $10 may not sound like much to middle class folks, but our clients faced with those copays will delay seeking care until illness generates into emergency.

One study I mention in my testimony shows a 10 percent increase in short-term risk of death among hypertensive low-income people exposed to copay system. A serious problem. Loss of Medicaid supplemental benefits for noncash recipients also.

Mr. Vladeck made a very important point today. There is some news in his testimony. He said the States would have the freedom to provide supplemental Medicaid benefits to noncash adults. That is different than the bill as we read it. Section 4221(b) of the initial version of the Health Security Act as we understand it forbids States from providing anything but long-term care and Medicare cost sharing to noncash recipients and to folks who do not receive Medicare.

So this is an important positive development we heard about this morning. But more developments are needed. Specifically, we think it is critical to make sure income is the criterion for assistance not receipt of cash aid.

The second issue I would like to briefly discuss this afternoon relates to quality. We fear that low-income people may be the only folks who are locked into Medicaid—excuse me, locked into managed care closed panels.

The point of service option now part of the bill is an enormous positive step forward and lets people go outside their managed care plans if they can pay to have copayments, 20 percent as a minimum and probably more. So for most middle class people, if they need to, they can get outside their plans.

For our clients they cannot afford those copays, so people of low and moderate income will be the only folks locked into closed panel HMO's, which is a new and dangerous form of health care segregation.

To rectify this we recommend, at a minimum, low-income people who can show their health care needs cannot be met inside their managed care plan should have the point of service copays reduced to the same level that they are in the plan.

Our concerns about quality are great because under a capitation system, obviously, the fewer benefits the managed care plan provides, the more money you make. And we have seen with Medicaid beneficiaries around the country horrendous denial of essential services thanks to this incentive for underservice.

We give a few examples in our testimony of a child who needs a tooth extracted and the managed care program says you can have it extracted but no anesthesia; and another child with a 104 temperature was given an appointment 2 months in the future.

Quality protections are critical and they are absent in large part from the bill. The bill does mandate the collection of data, but does not mandate national establishment of quality standards. That is given to the States, and we worry greatly, based on their track record in other areas, that those quality protections may not be adequate, and we look forward to working with you to address these problems.

Mr. WAXMAN. Thank you very much Mr. Dorn.

[Testimony resumes on p. 637.]

[The prepared statement of Mr. Dorn follows:]

Testimony of
STAN DORN
MANAGING ATTORNEY, WASHINGTON OFFICE
NATIONAL HEALTH LAW PROGRAM

Chairman Waxman, members of the Subcommittee, good morning. The National Health Law Program is the legal services national back-up center specializing in health issues affecting low-income people. We work with hundreds of legal services offices across the country to help their indigent clients receive necessary health care.

Chairman Waxman, it is a real honor to be here this morning. No one in the Congress has done more than you to help our low-income clients obtain essential medical care. Millions of vulnerable people throughout the country have health care today thanks to your efforts, and I would like to take this opportunity to thank you. It is also an honor to be here before other distinguished members of this Subcommittee, who have been vigorous champions of consumer interests in health care issues over the years.

When my wife and I got married, we served Moroccan food at our reception. I remember one side dish in particular. It combined sweet orange slices and pungent, North African olives. The Administration's health care plan likewise combines very different ingredients, some sweet and some not so sweet. I would like to discuss both sides of the Administration's bill this morning, including some key positive elements that must be preserved, and some areas where we believe the bill needs improvement, from the perspective of Medicaid beneficiaries and other low-income people.

Obviously, time constraints prevent a full discussion or even a full listing of all the important issues from our clients' perspective. I would be delighted to work with members of the Subcommittee to provide any additional information that might be useful on these crucial aspects of health care reform.

POSITIVE ELEMENTS OF THE ADMINISTRATION'S PROPOSAL

One crucial positive feature of the President's bill is that it provides nearly universal coverage at a date certain. Other bills before the Congress either do not provide universal coverage or make full coverage contingent on first achieving savings. The millions of low-income people now without health coverage cannot afford to wait. For them, delay means irreparable harm.

A second key feature of the Administration's bill is that it attempts to "mainstream" low-income people, permitting them to enroll in the same health plans that serve their middle-class neighbors. This goal is crucial. To the extent we continue with health care delivery systems segregated along economic and often racial lines, those in the bottom-tier system will suffer inferior quality and access to care.

The bill seeks to achieve this important goal in several ways. First, it provides that health plans receive the same basic payment for all consumers, including recipients of cash assistance. It does this by "blending" Medicaid payments and private insurance payments at each health alliance, and then paying health plans at a single, blended rate. The bill even requires the payment of risk adjustments to encourage plans to take consumers likely to generate above-

average costs, and the National Health Board. is required to consider factors such as socioeconomic status, geography and receipt of cash assistance in fixing nationally mandated risk adjustments.

The blended rate is vital to our clients. Perhaps the most serious access barrier confronting Medicaid beneficiaries today is that most providers refuse to accept Medicaid, citing inadequate reimbursement and inordinate payment delays. Equalizing reimbursement among all consumers will encourage providers to serve our clients. This would be an enormous step forward.

To fully realize its potential, however, this portion of the Administration's proposal needs several improvements. First, the risk adjustment mechanism should be made more secure, if possible. Many doubt the ability of the National Health Board and alliances to determine appropriate amounts for prospective risk adjustments that would adequately compensate health plans for increased costs. One approach to improving the risk adjustment mechanism would be to provide for annual, retrospective adjustments. At the end of each year, data could be gathered, either nationally or in smaller geographic areas, showing the average increased costs associated with each risk adjustment factor. Retroactive corrections in reimbursement for such factors could then be made, up and down as needed, resulting in risk adjustment payments reflecting the average increased costs associated with each risk factor.

Two other improvements are needed here. First, states should be required, not merely permitted, to provide additional risk adjustments, incentives and enabling services that will encourage health plans to take underserved populations and to help assure that those whose daily lives are difficult beyond belief receive the assistance they need to obtain medical care. Also, alliances should reimburse health plans for reduced co-payments from recipients of AFDC and SSI. Under the bill in its current version, health plans would not be paid for such co-payment discounts, and so would receive reduced compensation for such consumers.

Overall, Chairman Waxman, these areas of the bill require improvement, but their thrust is very important and very positive for low-income people.

AREAS OF NEEDED IMPROVEMENT

I would like to focus the remainder of my remarks on two sets of issues: the role cash assistance plays in the Administration's bill, and the potential that low-income consumers might be among the only people locked into closed-panel managed care plans offering poor quality and limited access to care.

The Role of Cash Assistance

Protections for cash assistance recipients. The Administration's bill, quite properly, acknowledges that those without means require special assistance to obtain the same access to health care enjoyed by their more affluent neighbors. Accordingly, recipients of AFDC and SSI

would not pay health premiums unless they chose a plan above the regional average price. This makes sense. Asked to pay health premiums, poor people would be forced to do without other necessities of life. Already, more than one quarter of Medicaid beneficiaries report difficulty buying food, paying heat bills, or paying their rent or mortgage.[1]

The bill also provides that cash assistance recipients receive 80% reductions in HMO co-payments, except for the $25 co-payment for receipt of non-emergency care in emergency rooms. This provision is an important step in the right direction. Asked to make co-payments that most of us would view as small, low-income people delay seeking health care until illness degenerates into emergency. This both damages health and increases costs, as some key public health studies show:

•One Rand Corporation analysis found that, when Medi-Cal, California's Medicaid program, imposed a $1 co-payment on the first two physician visits per month in 1972, physician visits declined by 8%; inpatient hospital utilization rose by 17%; and overall program costs increased by 3-8%.[2]

•Another Rand Corporation study found that, when low-income people with heart problems were exposed to a range of co-payments, the resulting hypertension increases were associated with a 10% average increased risk of death within a year.[3]

Although the reduction in co-payments for cash assistance recipients is an important and positive step, it does not go far enough. Co-payments of $5 per outpatient psychotherapy visit, $2 per physician visit and $1 per prescription will deter receipt of needed care. They will be a particular problem for low-income people with health conditions requiring frequent services, such as seniors, the disabled and HIV-positive people. Under Medicaid, by contrast, states most commonly do not charge co-payments. (A chart setting out state Medicaid co-payment levels will be provided to each of you next week.)

The co-payment for non-emergency use of emergency rooms is a very serious problem. Twenty-five dollars can be a family's food budget for most of a week. Rather than make this financial sacrifice, even families experiencing medical emergencies will delay seeking care until they are <u>sure</u> emergency room personnel will agree that it is a legitimate emergency. I know of at least one legal services client who has died under such circumstances, even under the far less harsh Medicaid co-payment rules now in effect.

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[1] Blendon, Donelan, Hill, Scheck, Carter, Beatrice, Altman, "Medicaid Beneficiaries and Health Reform" <u>Health Affairs</u> (Spring 1993) p. 141.

[2] Helms, <u>et al.</u>, "Copayments and the Demand for Medical Care: The California Experience," 9 <u>Bell J. of Econ.</u> 1 (1978).

[3] Brook, <u>et al.</u>, "Does Free Care Improve Adults' Health?" 309 <u>New England J. of Med.</u> (Dec. 8, 1983), 1426, 1431, 1433, (Table 8).

This problem is made more difficult because the bill's definition of emergency closely resembles that used in the COBRA hospital anti-dumping statute. Emergency room personnel who, for whatever reason, do not provide stabilizing treatment must affirm that the patient was not experiencing an emergency, or they will expose themselves and their hospital to potential liability under COBRA.

Moreover, in areas without sufficient primary care infrastructure, the emergency room remains, for many low-income people, their only source of primary care. Twenty-five dollar co-payments will prevent the delivery of primary care in these areas. Unfortunately, these serious provider shortages will not disappear overnight after passage of health care reform, particularly if the Administration's proposed public health initiatives remain mere authorizations of appropriation.

A final problem with the bill's protections afforded to cash assistance recipients is that Medicaid's access safeguards may no longer apply. Under the Medicaid program, providers must serve those who cannot afford "up-front" co-payments, billing them afterwards. Further, under Medicaid, states can impose limits on total household co-payments, to protect those with particularly great health care needs.

We would recommend several changes to the co-payment protections afforded to cash assistance recipients:

•First, those with very low incomes should be exempt from co-payments.

•Second, Medicaid co-payment practices should apply to low-income people under this new program, both in determining the amount of nominal co-payments and in protecting access to care. The current Medicaid option of imposing household limits on co-payments should apply nationally, pursuant to standards set by the National Health Board.

•Third, emergency room co-payments should not apply where patients have no adequate access to primary care.

•Fourth, emergency room co-payments should be reduced.

•Fifth, emergency room co-payments should not apply where the patient reasonably believes that he or she is experiencing an emergency.

Finally, the Administration's bill permits Medicaid benefits that exceed the standard package to continue in effect for cash assistance recipients. Such benefits are needed, because poor people, by definition, do not have the money to purchase health care that those with means can afford. Further, poverty is associated with disproportionate health care needs, such as those resulting from poor nutrition, inadequate housing and violence. Also, poverty is often the result of physically or mentally disabling conditions that require particularly great amounts of care.

Here are a few examples of services often covered by Medicaid programs that exceed the standard benefits package.

•Dental care and eyeglasses are covered by nearly 90% of Medicaid programs.[4] These services are outside the initial standard benefits package for adults under the Administration's bill. Poor people, unlike middle-class people, cannot pay for these services, which are often critically important to employment.

•Physical therapy services likewise are covered by nearly 90% of the states,[5] subject to federal requirements that services must be provided to the extent needed to achieve their objective. By contrast, under the Administration's bill, services are denied when (a) the patient suffers from a congenital condition; or (b) services merely prevent deterioration in function but do not cause improvement within sixty days. These extra, Medicaid-covered services are critical to many disabled and elderly people.

•Mental health and substance abuse services likewise are now provided by Medicaid programs subject to those same federal requirements that medically necessary care must be provided. Under the Administration's bill, outpatient psychotherapy is restricted, as a general rule, to 30 visits per year; and hospitalization is limited, as a general rule, to 30 days per spell of illness, and 60 days per year. This limited scope of service is grossly insufficient for people who suffer from serious mental illness, many of whom become poor as a result. The more generous Medicaid amount, duration and scope requirements are critical to their well-being.

•Critical enabling services are often covered under Medicaid. Necessary transportation must be furnished, as a matter of federal law, for example. Forty-three states cover case-management services,[6] which "hook up" Medicaid beneficiaries with health care and other needed services. These enabling services often are needed for poor people to actually receive health care. Insurance, while essential, is not enough.

It is very important that the Administration's bill preserves these services for cash assistance recipients. We would urge one improvement here, however. The transitional provisions of the bill forbid private insurance companies from making various cutbacks in coverage. The states should likewise be required to maintain current levels of Medicaid coverage, to prevent cutbacks that will both harm low-income people and increase the ultimate cost of health care reform.

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[4]Congressional Research Service, Medicaid Source Book: Background Data and Analysis (A 1993 Update) (January 1993) (hereinafter, "Medicaid Source Book") pp. 256-57.

[5]Id.

[6]Id.

Protections for low-income people not receiving cash assistance. For low-income people with incomes at or below 150% of the federal poverty line, the bill's protections are dangerously weak. First, unlike cash assistance recipients, who have premiums fully subsidized up to the regional average-priced plan, other low-income people must pay a share of their income in premiums. As noted above, when poor people are asked to pay more for health care, they must sacrifice other necessities of life, such as food, clothing, shelter and heat.

For the 20% "family" premium share, low-income household obligations rise rapidly from 0% for those with only $1,000 in annual income, to 3.3% for families with poverty-level incomes, to 3.9% for all households with annual incomes below $40,000. Under the current version of the bill, many poor people will also be asked to pay part of the 80% employer premium share. These are people who:

•work less than 40 hours a month for a particular employer, which excuses that employer from premium contributions;

•receive certain kinds of unearned income; or

•earn more than $5,000 during a month from an employer required to make premium payments.

Many low-income people work for several different employers, often for less than 40 hours a month per employer. This is often the case for migrant farmworkers, for example. Households with over $1,000 in annual income from these sources will be asked to pay part of the 80% employer premium share, with rising caps reaching 5.5% of household income at the poverty line, and the termination of subsidies entirely at 250% of poverty. A poverty-level family forced to pay both premium shares could be forced to pay 9.4% of family income for health premiums. This would wreak great harm among those who already go without the necessities of life.

In terms of co-payments, the bill's protections are even sparser. The bill provides that, if no lower-cost or combination plan is available, low-income people can enroll in fee-for-service plans and receive subsidies that reduce co-payments to the amounts required in lower-cost or combination plans. Low-income people will be asked to pay the same HMO co-payments required of those with much higher incomes:

•$10 per doctor visit
•$5 per prescription
•$25 per outpatient psychotherapy visit

As I mentioned a few moments ago, these co-payments will force poor people to defer care until illnesses become emergencies. This runs directly contrary to the Administration's goal of cutting costs by helping people receive care early in the development of illness.

It should be noted that the Administration's bill exempts from co-payments a narrowly-defined category of preventive care, including immunizations, tests, check-ups and prenatal care. This is a positive feature of the bill that acknowledges the potential deterrent effect of co-payments. However, primary care visits early in the development of illness, or to keep chronic illness from raging out of control, also are subject to deferral of care among indigent populations if subjected to unaffordable co-payments.

Finally, in terms of Medicaid benefits, the bill does provide continuing supplemental coverage for certain low-income children not receiving cash assistance. We support the goal of this provision, but have some concerns about the details. Rather than list these concerns exhaustively, I will mention two, leaving the rest to my able colleague from the Children's Defense Fund. First, the bill's coverage ends at the child's 18th birthday. Forty-one states currently offer Medicaid coverage for low-income children up to age 21.[7] Another seven states cover children up to age 19 or 20.[8] Accordingly, in most states, low-income children without cash assistance will lose benefits, under the Administration's proposal.

In addition, the Administration's bill would change coverage for non-cash children from an enforceable, legal right, based on the child's need, to a capped, federal obligation that terminates when fixed appropriations expire. This would expose children to the risk that treatment will be disrupted towards the end of the federal fiscal year, often causing irreversible harm.

Critically important, the bill ends Medicaid supplemental coverage for poor adults not receiving cash aid. This includes medically needy adults, who receive Medicaid coverage often because of very serious health problems requiring extensive services. Ironically, just these adults with particularly great needs are singled out for cutbacks. It is astonishing that, to help finance universal coverage, the Administration has asked some of the most vulnerable people in America -- people who are poor and sick -- to surrender currently available, essential care.

Implications. Aside from the consequences I have already mentioned, the Administration's general approach, which makes receipt of cash aid the prerequisite for much assistance with health care, has several implications.

•**Punishing poor people who work.** Low-income people who leave AFDC for employment, or who are ineligible for SSI because prior work history gave rise to current Social Security income, will pay more for their health care and, among adults, receive fewer services than will other low-income people.

•**Creating irrational interstate disparities.** AFDC levels vary radically among the states. For example, while Alabama pays $164 a month, Hawaii pays $693 a month. Identically needy families in different parts of the country will receive very different

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[7] Medicaid Source Book, pp. 180-81.

[8] Id.

levels of health care assistance, based purely on their state of residence.

•**Shortchanging those who choose not to have children, or cannot have children.** Childless, non-elderly, non-disabled adults cannot qualify for AFDC or SSI, no matter how poor they are. Under the Administration's proposal, a needy family with children could receive essential health care assistance that is denied to an even needier family, just because the latter family chose not to have children, or could not have children.

Recommendations. The same low-income assistance the Administration's bill provides to recipients of AFDC or SSI (with the changes outlined above) should be provided to poor people who do not receive cash assistance. A sliding scale for premiums could begin above a certain income level, which should not be less than the poverty line.

This is not a radical approach. Another bill before the Congress, with much bi-partisan support, takes this general approach, limiting co-payments to Medicaid levels for those with incomes below 200% of poverty; paying premiums fully for those with incomes below poverty, then requiring a sliding scale from poverty to 200% of poverty; and providing common, Medicaid supplemental benefits to all households with incomes below poverty. Although the bill has certain problems, this element of the basic approach to low-income assistance -- making eligibility depend on income, not receipt of cash aid -- is one we recommend.

One legitimate advantage of using cash assistance to determine benefits is that it promotes administrative simplification. Such simplification should be sought more broadly than it is under the Administration's bill, however. Receipt of other means-tested benefits, such as food stamps, fuel assistance or school nutrition programs, could be used as a proxy for eligibility, to reduce administrative costs. Other programs' income calculations could be used to determine eligibility for low-income health assistance, so long as applicants could instead have the choice to define income along the somewhat different lines used in the Adminstration's bill.

Despite these other means-tested programs, it will be essential to provide a residual low-income assistance program, as is done under the Administration's bill. Many low-income people do not receive any assistance. We must ensure that, if their incomes are sufficiently low, they receive the aid they require.

Managed Care Plans -- Issues of Mainstreaming and Quality

Mainstreaming. One of the great improvements made to the Administration bill after the September 7 draft is the "Point of Service" option. Each managed care plan must permit its enrollees to go to non-network providers, if the consumer pays significant co-payments, as determined by the National Health Board. Such co-payments must be at least 20%, but probably will be more.

For those who can afford these co-payments, this represents a critical safeguard. If managed care plans provide inadequate access or quality, the consumer can go outside the plan

for care. It also strengthens the consumer's ability to choose his or her own doctor.

Unfortunately, low-income people cannot afford these significant co-payments. People of low and moderate means may be the only ones unable to buy their way out of closed-panel managed care plans. This represents a new and potentially dangerous form of economic segregation in the delivery of health care.

This problem has extra dimensions for the disabled. The Administration's September 7 draft recognized that people with disabilities often are ill-served by managed care plans. Among other factors, managed care networks often lack the variety of specialized providers needed to treat people with disabilities. Accordingly, the September 7 draft provided special, subsidized access to fee-for-service plans for disabled people, until the National Health Board found that managed care networks were adequate to care for the disabled. Unfortunately, that provision is absent from the bill. Many low-income disabled people will now be locked into managed care networks unable to meet their needs, and they will be unable to afford the point-of-service option that could have been their lifeline.

Quality. The experiences of our low-income clients illustrate the need for strong consumer protections to safeguard quality of care. Enrollment in Medicaid managed care nearly doubled between 1987 and 1992.[9] During Fiscal Year 1992 alone, Medicaid enrollment in managed care increased by 35%.[10]

Managed care dramatically reverses the incentives affecting the health care industry. As the GAO noted, "While fee-for-service payments give providers incentives to provide too many services, capitation payments give providers incentives to provide too few services."[11] Without strong consumer protections, this incentive to underserve can create serious harm.

We frequently receive calls from legal services advocates attesting to this harm. For example:

- A 51 year old woman in Los Angeles with a history of severe hypertension suffered from chest pains and swollen joints. She could not get an appointment with her managed care plan for nine months. In the meantime, her four-year old son suffered a febrile seizure, with a 104-degree temperature. The managed care plan offered only an appointment more than two months away. Finally, the mother and her son went outside their managed care plan to a private doctor, who found that the mother was at grave risk of heart attack and that the child needed immediate treatment.

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[9]GAO/HRD-93-46, MEDICAID: States Turn to Managed Care to Improve Access and Control Costs (March 17, 1993) p. 4.

[10]HHS News (Nov. 30, 1992) p. 1.

[11]GAO/HRD-93-46, supra.

•In Miami, Florida, a young child's tooth became infected and needed to be extracted. The managed care plan informed the mother that it would extract the tooth, but without anesthesia.

•Over the summer, our office received a call from a 19-year-old in Fresno, California in her ninth month of pregnancy. She had tried repeatedly to obtain prenatal care from her managed care plan, which persistently turned her away, after making her sit in its waiting rooms for hours at a time. Finally, an unaffiliated obstetrician informed this teen that the managed care plan did not include a single maternity care provider. When I spoke with her, she had tried, unsuccessfully, to disenroll from the plan so she could receive prenatal care elsewhere. We do not know whether this high-risk pregnant teen received more than one, out-of-plan, prenatal care visit, despite great efforts on her part.

•In San Bernadino County, California, one managed care plan routinely disenrolls patients who are admitted to the County's trauma care center. While this saves money for the managed care plan, it denies care to patients for thirty days or more as fee-for-service eligibility is re-established. As a result, many low-income people have been denied crucial care, such as follow-up skin graft clinic treatment after admission for severe burns.

These are not isolated examples. The GAO recently found that "there have been problems with quality of service and high disenrollments, suggesting beneficiary dissatisfaction." The GAO also found that states and plans have not always complied with quality assurance systems and procedures.[12]

The Administration's bill, unfortunately, contains fewer safeguards than were promised in the September 7 draft paper. Although the bill directs the National Health Board ("Board") to develop performance measures, the Board has no power to set minimum quality and access standards for health plans. Minimum national standards are set for marketing and capital -- which is a positive and important feature of the Administration's bill -- but no national minimum standards are set for quality and access to care. These issues are left entirely to the unfettered discretion of the states.

The absence of minimum, federal quality requirements could endanger any consumer. Low-income consumers, however, who will face unique barriers to escaping from their managed care plans, will be particularly endangered. At the state level, when lobbyists for health plans go head-to-head with advocates for low- and moderate-income consumers, the health plans may often come out ahead. Such an outcome is suggested by the dismal record of the states in regulating their own Medicaid managed care plans, as well as many years' experience with state health planning boards, which often were "captured" by the health industry.

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[12]HRD-93-67, supra, p. 43.

These issues can be illustrated by analogy. Suppose we took this same approach to auto safety. We could mandate that each car manufacturer must make available to the consumer, through automotive alliances, comprehensive information about each car, from Pinto to Cadillac. No federal safety rules, however, would forbid manufacturers from selling cars with exploding gas tanks -- quality regulation would be left to the unfettered discretion of the states. Most of us would agree that a strong federal role is needed to set minimum standards for auto safety, not merely to specify the relevant information that must be collected and passed on to the consumer. Such minimum federal standards are no less necessary to assure quality health care in our new, managed care environment.

Recommendations. Several changes to the bill would address these problems:

•First, point-of-service co-payments should be reduced to the level of in-plan co-payments for certain groups of consumers, including low-income consumers who demonstrate a health need to go outside their managed care network; people with rare diseases; and migrant workers who reside in distinct alliance regions for less than three months a year and, without point-of-service or fee-for-service coverage, would be restricted, under the Administration's bill, to urgent care and emergency coverage.

•Second, the National Health Board should be directed to develop minimum, quantified quality and access standards applicable to all health plans. These requirements should include measures addressed to underserved populations and groups with special health needs.

•Third, the legislation should make these standards enforceable. For example:

° Aggrieved consumers should have a private right of action to remedy and seek compensation for health plans' violations of federal or state standards. Such rights should be comparable to consumers' rights, under the Administration's bill, to sue for legal violations by Alliances and states.

° Health plans that violate quality or access standards should be barred from enrolling new consumers at least until such violations have been rectified.

° When consumers are harmed because of poor quality care or inadequate access to care, they should be deemed to have good cause to change health plans. The health plan that harmed them should be responsible for continuing to pay for their care at the new plan until the conclusion of either (a) the spell of illness or (b) the health consequences of inadequate care, whichever occurs later.

Overall, Chairman Waxman, the Administration's bill is an excellent base on which the Congress can build. If the positive elements are retained and necessary improvements are made, low-income people could obtain good access to quality health care for the first time in this country's history. Thank you.

STATEMENT OF GREGG HAIFLEY

Mr. WAXMAN. Mr. Haifley?

Mr. HAIFLEY. Good afternoon, Mr. Chairman. My name is Gregg Haifley and I am a Senior Health Associate with the Children's Defense Fund.

I would like to also join with other panel members in commending you for having this hearing today on the impact of the President's proposal on the populations that we care so much about, and also to commend you for your efforts in the past and the efforts of other members of this committee to extend Medicaid services to certain populations that had not been covered before.

Your accomplishments in the 1980's with regard to the expansions for pregnant women and infant children were monumental and tremendously important to the health of those populations. But as you know, and as the President has recognized in his proposal, those expansions still leave significant portions of our populations uncovered without any access to necessary and vital health care.

More than 8.5 million children and over half a million pregnant women who deliver each year are uninsured. The President's plan puts forward a fundamental reform of the health care system to ensure that every American is covered at all times without having the possibility of their coverage being dropped by their employer or by an insurance company, and we support the President's approach for taking this monumental step.

A second area of reform that is important when discussing not only who is covered, but also under reform what is covered by the benefits package. We also believe that the benefits that are provided under the benefit package must be adequate and have stable funding to ensure their continued availability.

You and the Members of the Congress have recognized that EPSDT services are a necessary broad range of services necessary to cover the needs of low-income children. The President's standard benefit package covers a wide range of services but, in addition, recognizes that certain wraparound services must continue for low income infants and children, and we commend the President for those proposals.

We would suggest that the proposal be expanded to cover low-income people up to a higher income level for these necessary wraparound services.

A third area of reform that is critical that Stan mentioned so eloquently, is the issue of mainstreaming. Medicaid recipients in the past have received less than mainstream services, and we believe that the President's proposal, at least to the extent that low-income people will have the opportunity to enroll in alliances and plans that all people have access to, have the potential for mainstreaming Medicaid and other low-income people in a critical way.

However, we too are concerned that low-income people may be relegated to low cost plans and that these have the potential for being poor people's plans.

We think the cost sharing levels that are a part of the reform proposal are positive in that they recognize the need for significant reductions for the cash assistance Medicaid eligible population, but we would also advocate, as many other people today have indi-

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cated, that those cost sharing adjustments apply to higher income, poor and near poor individuals.

The Congress has recognized that cost sharing is a potential barrier to care, and in recent reports from the Office of Technology Assessment, they caution the Congress that in health care reform it is the low income and sick low income populations for whom cost sharing can pose the most damaging barriers to access to care, leading to more expensive health care later on.

The final area that I would like to mention in terms of health care reform, in terms of special populations that we would like to see Congress pay particular attention to are those children that are currently covered by the Medicaid system who are foster care children, for whom enrollment and portability and continuity of coverage is going to be critical to where they live, and these are children that are moved frequently in the foster care system.

We look forward to working with you and other members of the committee and the Congress to see that those children get the services they need in terms of the scope as they get under the Medicaid program now, but also in the method of the delivery of those services.

I finally mention that we are concerned about the reliance on Medicaid cost savings as one of the significant approaches to financing health care reform and we will be watching that very carefully to see what the impact of that will be on Medicaid recipients.

We thank you for your efforts on behalf of the low income populations and look forward to working with you as the health care reform debates moves forward.

Thank you.

Mr. WAXMAN. Thank you very much. Appreciate that.

[The prepared statement of Mr. Haifley follows:]

Gregg Haifley
Senior Health Associate
Children's Defense Fund

Good morning, Mr. Chairman and members of the Subcommittee. My name is Gregg Haifley. I am a Senior Health Associate at the Children's Defense Fund. We want to thank you for holding this hearing on the impact of the President's health care reform proposal on Medicaid recipients, low-income people and other people who are medically underserved. We appreciate having the opportunity to testify today on these issues of great importance to millions of low-income children and their families.

As you know all too well, the nation's Medicaid system has had to serve as the safety net for the delivery of health care to millions of people. Over the past several years, the Chairman and this Subcommittee have led the fight to guarantee that low-income people get access to health care. You particularly worked to expand basic health care coverage for low-income children and pregnant women. This was a major accomplishment in the 1980's. Yet these critical expansions have not been able to keep pace with the declining private insurance coverage of children. Today, more than 8.5 million children--mostly from moderate income families--and one-half million uninsured pregnant women who give birth each year are uninsured, as are millions of additional adults. These people deserve access to health care as well. We must act now to assure that <u>all</u> children and adults are insured.

The first and most fundamental principle for health care reform must be that every American must be insured, at all times and with no insurance company or employer able to discontinue an individual's or families' coverage. The way to achieve this goal of universal coverage is to involve employers in paying a substantial share. The President's plan meets these critical tests. We support it for that reason, and applaud its goal of giving health security to all

Americans. This proposal will provide health insurance to all of the poor and moderate income children not currently covered by Medicaid. And while most poor children are covered by Medicaid now, the extension of health insurance to all of their parents, millions of whom are uninsured, is an absolutely essential step to health and economic security for poor families.

A second fundamental principle of reform is that children must receive a comprehensive package of benefits which meets their diverse health and medical needs. These benefits must have adequate and stable funding to assure their continued availability. Design of a benefits package in particular must take into account the health care needs unique to low-income children. Congress has defined the scope of Medicaid services for children with the understanding that low-income people represent medically underserved populations with health care needs that are compounded by poor health status associated with poverty. For children, the Medicaid benefit package has included EPSDT, which, as you know, covers a whole range of services (such as case management, rehabilitation, and screening) which have proved critical for children with developmental, physical or emotional problems.

The President's standard benefit package proposal covers a wide range of services. In addition to the preventive services, physician visits, prescription drugs and other services available to adults as well as children, notable services specifically addressing children's health include immunizations, dental, and vision services. We believe that the package also should cover outpatient rehabilitation services for all children, including those children with chronic or congenital conditions.

The President's health care proposal also recognizes that Medicaid beneficiaries should continue to receive comprehensive benefits, including, for poor children, a wrap-around package

of benefits which are not included in the standard benefit package. These additional benefits include certain crucial rehabilitation benefits as well as other vital services. The wrap-around benefits are available to all children who are eligible for Medicaid, not just cash assistance children. This is important since it includes key health care that no poor or near-poor family can afford on its own. We would support extending these crucial services to more children--at least to all children with family income below 150% of the federal poverty level. This is the income level used in the President's plan for purposes of determining eligibility for premium discounts in the low-cost plans. This would be an inexpensive and, in the long term, cost-effective investment in the nation's children and its future.

A third fundamental principle is that all individuals must be part of the mainstream health care system, regardless of the source of payment for their health care. Of course, Medicaid-eligible children, though in theory eligible for comprehensive benefits, have not always enjoyed meaningful access to services. This is the result of inadequate provider participation in the delivery of care, fostered in part by inadequate provider reimbursement levels set by the states. This fundamental problem in Medicaid must be fixed through health reform.

The President's proposal is designed to mainstream low-income people in the health care delivery system in a number of ways. Medicaid eligible children and adults will no longer carry a separate Medicaid card and should enjoy increased access to care through enrollment in a health care plan available to anyone in that alliance. These plans are to be designed so that they do not distinguish between patients on the basis of the income of the patient or the source of payment for services delivered. Moreover, the alliance will pay the same rate or fee to providers for all enrollees in that plan, which is essential to protect low-income families from continued

discrimination.

Assuring that low-income people actually receive medically necessary services under plans and additional services provided through safety-net providers is a fourth fundamental element which must be part of health care reform. The experience of Medicaid beneficiaries in managed care has been, at best, a mixed one. Safeguards and standards are especially necessary because low-income people typically will have access only to lower-cost plans, since they will not be able to afford the premiums and cost-sharing requirements of higher-cost sharing plans. The lower-cost plans have the potential of becoming overwhelmingly "poor people's plans" in some localities. Strict guidelines must be put in place to guarantee that marketing approaches of health plans, geographic territory covered by health plans, and links between health plans and essential community providers funded through the Public Health Service Act work toward mainstreaming low-income people in the health care delivery system. Health care plans will have to be monitored, and certain protections will have to be in place, to address incentives that plans may have to control utilization at the expense of access to necessary care.

A fifth principle for reform is that access to care must be affordable and funding for premium and cost-sharing subsidies must be adequate and stable. Congress has recognized that cost-sharing requirements can pose barriers to access to care for low-income people. Only very limited and nominal co-payments are allowed under the Medicaid program. It is essential that premiums and co-payments, particularly for low-income families, be kept very low in any health reform the Congress adopts.

The President proposes that Medicaid cash assistance beneficiaries (AFDC and SSI recipients) would pay only one-fifth of the cost-sharing requirement of lower-cost plans. In other

words, instead of having to pay the $10 co-payment per non-preventive doctor visit and $5 per prescription, Medicaid beneficiaries would pay $2 per doctor visit and $1 per prescription. While we are delighted the plan reduces co-payments for cash recipients to more nominal levels, such relief must be extended to other low-income families--poor and near-poor--as well. A recent Office of Technology Assessment background report titled "Benefit Design: Patient Cost Sharing" stated that *"...Congress should be cautious about the extent to which cost-sharing is relied on to control costs, especially for sick, low-income individuals. These individuals are the most likely to benefit from receiving health care services at no out-of-pocket cost and the most likely to be harmed by patient cost-sharing requirements."*

While $10 and $5 co-payments may not seem high to some, studies have shown that cost-sharing does prevent families, particularly low-income families, from seeking necessary care. To demonstrate the financial burden of co-payments, an example is a typical family of four (consisting of two parents and two children under 5) with a full-time minimum wage worker earning $8,500 per year. At the $10 per doctor visit and $5 per prescription co-payment level, they would pay an average of $265 in co-payments for doctor visits and prescription drugs (based on utilization information from the National Health Interview Survey and the National Ambulatory Medical Care Survey). This is the equivalent of a family of four at the national median income of $41,451 paying $1,296 for the same services--and this is in addition to what they would have to contribute toward their premiums. These co-payment estimates are based on average utilization rates, so families with children with chronic health conditions, for example, will experience significantly higher co-payment obligations. When premiums and out-of-pocket costs for excluded services are counted, these costs will be prohibitive for many families. Health

security for families with incomes at least below 150% of the poverty level will require co-payment protections similar to those of cash assistance Medicaid beneficiaries.

We are concerned about heavy reliance upon savings from Medicaid to pay for coverage of the uninsured given how underfunded the Medicaid program is today. Whatever mechanism is chosen to pay for coverage for low-income individuals, families and their children, the health reform plan must include entitlement funding for the crucial subsidies and wrap-around benefits.

Finally, let me mention a few issues relating to special populations of children. Many children and adolescents in the foster care system receive health care services through the Medicaid program. These children will continue to require the Medicaid scope of benefits and they will need special attention, since they get moved around so much, in order to assure that their coverage is portable and their access to health services is continuous. Similarly, the many children who live with one parent, adult non-parental relatives, or with non-relatives will also require enrollment and portability protections that guarantee that where they live, who they live with and who is paying their premiums will not pose barriers to access to the health care they need. We look forward to working with the Subcommittee to accomplish these goals.

We endorse the basics of the President's proposal as the soundest way to provide health security to all Americans. This hearing is an important step in moving that proposal forward by assessing the impact of the proposal on the low-income children and families in our nation. The President has provided crucial leadership in proposing this historic reform of our health care system to make access to health care a reality for children and their families. We know that this Subcommittee will also work to achieve the goal of providing universal and comprehensive coverage for children and their families. We look forward to providing any assistance we possibly can as you embark on this quest. The health of millions of low-income Americans depends on this Subcommittee and the decisions you will make over the next several months.

Thank you.

STATEMENT OF ANN KOLKER

Mr. WAXMAN. Ms. Kolker.

Ms. KOLKER. Mr. Chairman, I am Ann Kolker, Director of Public Policy for Health and Reproductive Rights at the National Women's Law Center.

I appreciate the opportunity to appear before you today on behalf of the law center, which has been working since 1972 to advance and protect women's legal rights.

National health care reform is a priority for American women. It is essential that the system, which is being designed to provide universal access, comprehensive coverage, cost effective and affordable care and that as this is done, the special needs of women are considered.

We have documented the problems that low-income people, who are disproportionately women, face in our written statement, so today we will focus on affordability and the way that the Clinton plan affects the low income population.

We join others in applauding the President's plan for offering important progress for women and their families. Universal coverage to all legal residents is offered, accompanied by a generous benefit package which includes primary and preventive care, with important preventive services for pregnant women; screening services such as Pap smears and mammograms offered free of charge.

These are critically important not only for the general population of women, but particularly for low-income women.

The subsidies issues, the subsidy schemes have been mentioned by many today, and so there is no need to further explain them.

We too join our colleagues in applauding the fact that Medicaid is folded into the new scheme. One result of this folding Medicaid in is that for the first time since 1977 abortions for Medicaid eligible women will be covered.

The general approach to Medicaid represents a giant step forward toward providing low-income individuals with the same access to and delivery of health care that those who can afford private insurance benefit from today.

We too have concerns, however. One is the loss of benefits that many pregnant women and children will receive because the subsidies cap at a 150 percent of poverty. There are numerous States that subsidize above the 150 percent of poverty level, and we are very concerned about this population that will lose benefits, who, as we know, are predominantly women and children.

Another problem is the cost sharing that has already been mentioned. This is a particular problem, as has been mentioned, in the point of service option that will be available—the point of service option that the administration has added to the low cost sharing plan, because it is our understanding that cost sharing will be available for AFDC and SSI recipients, but not for other low-income individuals.

There are several other aspects of the plan as it affects low-income women that concern us as well. One example is homemakers recently separated from their spouses. No longer qualified for coverage as a married couple, they will have to obtain coverage on their own. But without any financial contribution from an employer, they will be forced to pay for coverage by themselves unless

qualifying for a subsidy. This is particularly problematic for the husband is not required to notify his spouse that he has dropped her coverage, and will be further aggravated if there are not opportunities for reenrolling outside the annual open season.

Another problem concerns the failure of the plan to allocate responsibilities for children fairly between the employers of custodial and noncustodial parents. The employers of custodial families and custodial parents themselves will, it appears, be required to bear the complete cost of coverage for their children, particularly if the father is in another regional alliance.

Not only a financial hardship for the custodial parents and her employer, but also very unfair because absent other clarifications, neither the noncustodial parent nor his employer has any obligation to cover the children.

Finally, we are concerned about part-time workers, nearly two-thirds of whom are women. Although we are pleased to see that employers will be required to cover part-time workers, the fact that the employers will be allowed to prorate the cost for part-time workers could impose severe financial hardship on some of the part-time workers.

Mr. Chairman, in conclusion, President Clinton's health plan goes a long way toward redressing the inequities that women in our system face, providing for universal coverage and closing the gaps in our two-tiered system are to be commended. However, we believe that there are still clarifications and improvements needed in several critical areas that we have discussed to assure that proposed reforms in health care meet the needs of all Americans, including poor women, and we too commend the committee for what it has done in the past through Medicaid and other programs, and look forward to working with you as some of these issues are fleshed out and clarified.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Ms. Kolker follows:]

TESTIMONY OF ANN KOLKER
NATIONAL WOMEN'S LAW CENTER
BEFORE THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
ON
THE IMPACT OF HEALTH CARE REFORM ON
MEDICAID BENEFICIARIES AND OTHER LOW INCOME PEOPLE

Mr. Chairman and members of the Subcommittee, I am Ann Kolker, Director of Public Policy/Health and Reproductive Rights at the National Women's Law Center. I appreciate the invitation to appear before you today, on behalf of the National Women's Law Center. The Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including health care reform, reproductive rights, employment, education, family support and income security -- with special attention given to the concerns of low-income women and their families.

National health care reform is a major concern and priority of American women. As this Committee considers fundamental change in the health care system, the health care needs of all Americans, including women, must be addressed. It is essential that the system be designed to provide universal access, comprehensive coverage, and cost-effective and affordable care and that the special needs of women be considered as this Committee deliberates on how best to achieve each of these goals. Our testimony today will focus on affordability and the particular needs and concerns of low-income women and their children under the Clinton plan.

As this Committee well knows, women and their children are disproportionately represented in the ranks of the low-income population. Although 1990 figures, the picture is essentially the same today. Sixty percent of the 5.6 million poor households with children are headed by women. Thirty-seven percent of all individuals in female-headed households are poor, and nearly one-half (45%) of all female-headed families with children are poor compared to 9% of families with a male present. African-American and Latino families are particularly harshly affected.

I. The Plight of Low-Income Women Under the Current Health Care System

A. Medicaid Recipients

The Medicaid program has been a critical safety net for those at the very bottom of the economic ladder, providing essential health services to poor and near poor families. In recent years, the program has expanded to provide prenatal care, enhanced support services, and services to very young children available to a population even larger than that eligible for other health benefits. Medicaid has filled a critical need for many women and young children who -- absent Medicaid -- would undoubtedly have had high rates of low-birth weight babies, emergency room admissions, and delayed surgeries and procedures that are costly to themselves, to their families, and to the health care system generally.

However, even with the access that Medicaid provides, the program falls short for many. Although Medicaid is supposed to provide health insurance to those most in need, in reality this publicly funded health care program covers only 42% (26 million) of the poor and uninsured. Medicaid covers neither single people in poverty nor midlife women who are poor and no longer have dependent children. In addition, the program is limited in areas of specialization unique to women's medical needs. The willingness of physicians to accept Medicaid patients varies by specialty. Obstetricians and psychiatrists are the least likely to accept Medicaid patients. A 1987 survey found that only 63% of obstetricians were accepting Medicaid.

In spite of tremendous efforts to assure prenatal care, for many Medicaid beneficiaries it is still inadequate. Only 36% of Medicaid beneficiaries, as opposed to 81% of privately insured and 32% of uninsured women, obtain adequate prenatal care. Compounding the problem for women and their families, the percentage of pediatricians accepting Medicaid dropped from 85% to 77% between 1978 and 1989. These problems must be remedied under a reformed health care system.

B. The Uninsured

Even with its shortcomings, however. Medicaid must look like a Godsend to the twelve million American women who currently lack health insurance of any kind. Our employer based system makes women tremendously vulnerable, because their work and family patterns do not always fit traditional patterns. For example, 56% of employed men have health insurance coverage through work, but a mere 37% of employed women have employment-based health insurance. Women comprise 73% of those who receive employer-based coverage as dependents -- where employer cut-backs have been harsh in recent years and where the risk of losing coverage in the case of a separation, divorce, or death is ever present. Women also comprise almost two-thirds of the part-time work force -- a group only one-third as likely to have health coverage as full-time workers.

Indeed, divorced or separated women are twice as likely to be uninsured as married women. And single parent families, nearly 90% of which are headed by women, are far more likely than two-parent families to lack health insurance. Only 12% of two-parent families with a full-time worker, but 33% of single parent families with a full-time worker, are uninsured. Finally, women workers are disproportionately represented in the jobs paying under $20,000 where virtually all the uninsured workers (93%) are concentrated. For example, nearly half of all working women earn under $10,000 and a full 80% of working women earn under $20,000 compared to half of men.

Absence of health insurance has devastating consequences for women's overall health, denying them access to vital treatment or forcing them to miss prenatal care while pregnant. The failure of our health care delivery system to service poor and rural areas takes a serious toll on many women and their children, especially pregnant women and newborns. As this body deliberates on how to reform our current health care system, we urge you to bear in mind the health needs of those who are not insured through their employers and lack the resources to purchase their own private

insurance plans as well as those who, although covered through an employer, will find the costs they are required to bear too steep to enable them to find health security.

II. How Low-Income Women Fare Under the Clinton Health Security Plan

President Clinton's Health Security plan offers important progress for women and their families. The plan attempts to offer universal coverage to all legal residents accompanied by a generous benefit package. Preventive and primary health care are emphasized, with important clinical preventive services such as routine prenatal care for pregnant women, immunizations, and screening services such as Pap smears and mammograms offered free of charge in accordance with a set schedule. Employers are required to pay 80% of an average premium, with individuals paying the remaining 20% (or more, if they select a plan with a higher cost). Subsidies are available to families whose incomes fall below 150% of poverty, with subsidies greatest for individuals and families below poverty, and phasing out between 100% and 150% of poverty. In addition, families with adjusted income below $40,000 will not be required to pay more than 3.9% of their income for health care per year.

A. The Medicaid Population: Gains and Losses

Medicaid is folded into the new scheme, allowing Medicaid beneficiaries to enroll in the same health care plans offered to the population at large, and lessening the detrimental effects of the two-tiered system of health care that exists today.[1] Under the President's plan, all Americans will receive the same comprehensive benefit package, regardless of economic status. For the first time since 1977, abortions for Medicaid-eligible women will be covered, rectifying one of the injustices of our present system. This new approach represents a giant step toward providing low-income individuals with the same access to and delivery of health care that those who can afford private insurance plans

[1] Of course, in practice, most low-income individuals will be forced to opt for the lowest priced plans, but many non-Medicaid recipients will be enrolled in these plans as well.

benefit from today. Indeed, discrimination on the basis of income, occupation, and socio-economic status is expressly prohibited under the Clinton Health Security plan. While we applaud this effort in principle, we have concerns about its implementation.

Mainstreaming Medicaid offers potential for great improvements in access to health care for millions of Americans. However, certain Medicaid beneficiaries risk losing some of their current benefits under the Clinton Health Security plan. Today, Medicaid pays for enhanced prenatal care services such as nutritional counseling and transportation for medical visits for pregnant and post-partum women whose family incomes are as high as 185% of poverty in a number of states.[2] Under the Clinton Health Security plan, such supplemental services will continue as under current law only for AFDC/SSI cash recipients. This represents a loss of services for pregnant and post-partum women in many states. This is not what the President and his Administration -- who have often stated that their plan will provide Americans with the same or better coverage as they have today -- promised.

B. The Shortcomings of the President's Plan in Providing Affordable Coverage For All

Under the Clinton plan, low-income individuals, who are disproportionately women, will still be required to assume costs that may well impose serious financial hardship. Although they will be subsidized if their incomes fall below 150% of poverty, except for AFDC/SSI cash recipients, these subsidies are available only for premium costs and not for other costs that will be incurred. For example, the low cost sharing plan, which is the only option most low-income individuals will be able to afford, requires $10 to $25 co-payments for each visit. Thus, many low income individuals could

[2] Under current law, states must cover pregnant and post-partum women with incomes up to 133% of the poverty level, with the option to expand this coverage to those with incomes up to 185% of poverty. According to the National Governor's Association, as of January 1993, 26 states had expanded eligibility above the 150% level provided for in The Clinton Health Security plan.

find themselves choosing between medical care and other basic necessities, particularly in the case of someone requiring multiple visits.

Another problem is that while AFDC and SSI recipients will be subsidized if they select a point of service option (out of plan providers) under the low-cost plan, other low-income individuals will not receive subsidies for this option. The effect of this failure to subsidize will be a denial of equal access to the same choice of providers as others enrolled in the plan. Clearly this inequity must be corrected.

There are several other aspects of the plan as it effects low-income women that concern us. One example is homemakers recently separated from their spouse. No longer qualifying for coverage as a married couple, they will have to obtain coverage on their own. But without any financial contribution from an employer, they will be forced to pay for coverage by themselves, unless they qualify for a subsidy. This is particularly problematic if the husband is not required to notify his spouse that he has dropped her coverage, and will be aggravated further if there are not opportunities for re-enrolling outside the annual "open season".

Another problem concerns the failure of the plan to allocate responsibility for children fairly between the employers of custodial and non-custodial parents. The employers of custodial parent families and the custodial parents themselves will, it appears, be required to bear the complete cost of coverage for their children, particularly if the children's father is covered through another regional alliance. This is not only a financial hardship for the custodial parent and her employer but also patently unfair, because absent other clarifications, neither the non-custodial parent nor his employer has any obligation to provide health insurance coverage for the children.

Finally, we are concerned about costs that part-time workers, nearly two-thirds of whom are women, will be required to bear. Although they will benefit from the requirement that they are covered through their employer, the costs associated with this requirement could be prohibitively high

for some. Because employers will be permitted to pro-rate their premium contribution, some workers will be hit with higher monthly premium costs than their meager salaries can afford.

* * * * *

Mr. Chairman, in conclusion, President Clinton's Health Security plan goes a long way toward redressing the inequities that currently exist in our health care system. Providing for universal coverage of legal residents and closing some of the gaps in our two-tiered system of health care by folding Medicaid into the new scheme are two elements of the President's plan that must not be compromised away. Despite these commendable principles, however, clarifications, refinements and improvements in several critical areas are still needed to assure that we enact a reformed health care system that truly meets the needs of all Americans, particularly those of the poor, so many of whom are women. Our nation's health depends on it.

Mr. WAXMAN. I want to commend all of you for your testimony. It has been very helpful. Let me ask some questions, though.

Let me pose to each of you a question that I have asked of Mr. Vladeck and of the State witnesses at previous hearings, and I am interested in the beneficiary and provider perspective on this.

Under the President's plan the Federal subsidy payments to the regional alliances for low-income people, for small employers and for early retirees are capped each year. In the first year of implementation they cannot exceed $10.3 billion, over the first 5 years they cannot exceed $274 billion.

The administration argues these cap levels include a cushion totaling $44 billion over 5 years, and they say this is large enough to make the risk of hitting the cap negligible.

My question is what if the administration's estimates are wrong and the subsidy cap is hit? If the regional alliances do not have enough funds to pay their participating health plans, what will happen?

On paper at least individuals are still entitled to coverage for the specified benefits and their individual financial liability is capped, the employer contribution is capped, increases in premiums are capped, the Medicaid capitation payment on behalf of cash assistance eligibles is capped.

Who do you think ends up holding the bag, the beneficiaries, providers, plans, counties or the States? You want to jump into that Dr. Dennis?

Mr. DENNIS. Clearly, the providers are going to probably be holding most of the bag because they are not going to get paid for the services. They will have provided the service, the alliance will not have the money to pay them, and then they will be confronted with the situation where they are going to have to try to retrieve the money from the alliance because they cannot retrieve it from the patients.

The patients, on the other hand, may start to run into disgruntled providers because they cannot get paid. As a consequence of that, they may stop coming or start putting out their own money just to ensure that that part is paid.

I think that there could be a lot of problems, but, in general, unless something is legislated which either provides some kind of Federal insurance for the alliance so that in situations like this there is a special fund to cover that, the providers will probably lose a lot of money and the patients will become frustrated.

Mr. DORN. I think it is a really crucial point that you raise. I think just about every set of actors in the system is at risk if the Federal commitment is capped and cannot expand with the need. We are marching into the unknown here.

We do not know if the caps will be enough; and if they are not, the providers fear they are not going to get paid. The States fear they will have to step in and spend more money. We fear low income subsidies could be cut as a means of achieving budget savings in this highly deficit conscious environment.

I think everyone is at risk and it is crucial to make sure that, just as in the other successful programs that we run, Social Security and Medicare, where Federal assistance depends on individual

need not on Federal perspective budgeting, that the subsidies under this new program need to be fashioned in the same way.

And we are really grateful for your leadership in raising this issue repeatedly and we hope it gets improved.

Mr. WAXMAN. Mr. Haifley.

Mr. HAIFLEY. My only comment, Mr. Chairman, is in our testimony we mention that part of the access problem for Medicaid beneficiaries in the past has been inadequate reimbursement rates which then leads to inadequate provider participation which reduces access to benefits.

No matter how the dominoes fall, the bottom line question has to be what is going to happen to poor people's health in that environment?

Given the Medicaid experience, I think that you are absolutely right to raise the question about what happens. Because if we do not approach the reform system in a conscious way in terms of what everything does, in terms of access to care, we are potentially not addressing the inequities we face in the current system as we know it.

Mr. WAXMAN. Ms. Kolker.

Ms. KOLKER. I would just add that I think every major program, whether it is a public program like Social Security or a private program like private insurance, has to have some kind of cushion, reserve fund, a trigger that will go off when you get into a danger zone, and that you cannot set up a program and not ask yourself what is the worst case scenario if everything is more expensive than we thought, then what do we do.

And before the program is enacted there has to be a safety net for the safety net.

Mr. WAXMAN. Dr. Dennis, I was troubled by the point you made in your prepared statement on page 8 where you said with some exceptions white Medicaid enrollees have greater access to services than nonwhite enrollees.

Is this the result of the way the Medicaid program is currently structured or administered, or are there other causes?

Mr. DENNIS. I think there are other causes, but I think some of the causes just have to do with the lack of primary care in the African-American and other minority communities. Of course, there are very few providers in the community anyway, making it more difficult for the patients to gain access to routine primary care.

Second, because of that there are many extremes of illness that patients present to emergency rooms with so, therefore, what they do is overburden the system with severe illnesses and do not have a primary care doctor even after that. So, therefore, they do not interface with the system as often.

And then, third, of course, when the Medicaid recipient comes to the system to receive care, unless it is culturally sensitive, unless the patient is made to feel of worth, it is very likely the Medicaid patient will not access the system as a Medicaid patient should in order to receive proper care. So cultural sensitivity to providers is also very essential.

And in order to address this problem, certainly we need to increase the number of African-American and culturally sensitive

providers, increase the number of students, and all health care providers to address this kind of issue.

Also, there must be more representation of African-Americans, especially in decision-making capacities within the institutions and also in all aspects of this health care reform in terms of committees, councils, boards, et cetera, so that issues like this can be addressed.

Mr. WAXMAN. From what you know of the President's proposals, would it reduce these racial differences in access to covered services? And if so, how?

Mr. DENNIS. I think it would if there was, number one, an emphasis on an increase in the number of community, essential community providers, access to them as well as increasing the numbers of culturally sensitive African-American providers.

Those are some of the key issues. Access to health care, primary care in the community.

For instance, if a pregnant woman cannot gain access to health care because of lack of child care or transportation, it is very unlikely she is going to receive prenatal care. That may not be an issue in some communities, but certainly in the African-American community it is a significant issue.

So, therefore, that is not adequately addressed in this plan. I think we need to retool it a little, refine it to be sure that that kind of benefit is there.

Mr. DORN. I would like to agree with everything Dr. Dennis said, but just add racism has a fair bit to do with it too. I remember there was a study, and I may be getting the details wrong, but if I remember correctly, it dealt with coronary bypass surgeries and compared low income white elderly people's rate of receipt with low income African-American elders' receipt, and the ratio was 3.5 to 1. And in the southeast the ratio was 6 to 1. And I think that suggests there is racism at play.

In addition to the remedies Dr. Dennis mentioned, I think a couple of other factors should be thought about. One is the anti-discrimination provisions in the bill are positive and need to be preserved, but they need to be improved a little bit.

And rather than take a tremendous amount of time now, I will mention one major improvement: Collection of data. You cannot prove discrimination without data, and the bill does not provide a means of tracking race-based utilization and race-based outcomes. That is a major improvement.

There are others I would be glad to work with you and your staff on.

The second thought I have, I think it would be helpful to require States to achieve quantified goals in narrowing racial and economic disparities in health utilization and status, put the burden on them, and let them be creative in meeting those objectives, but do it in an accountable and enforceable way. That would be a big step forward to address these serious problems.

Mr. WAXMAN. Let me ask another question to whichever of you wishes to respond. I asked this question of Diane Rowland this morning. Some argue that universal coverage for comprehensive benefits as the President is proposing is not necessary to ensure adequate access to health care for uninsured people; that all we

need to do is put some additional resources into community health centers and those underserved areas that do not have sufficient primary care capacity.

Would investment in primary care infrastructure be equally effective as a strategy for improving the access of uninsured low-income people to basic health care?

Mr. HAIFLEY. Well, Mr. Chairman, my response to that is, obviously, improvements in the safety net structure would be helpful, but it is not going to address the need.

We are looking at a health care environment where even those with insurance face health care insecurity. And as long as the system is set up where everybody is vulnerable at any given moment in their lives to not having coverage for the care that they need, measures that address shoring up certain safety net structures, while positive in what they may be able to accomplish, may not go far enough, obviously, in reaching what we have to do to give health security to all children in particular in this country for preventive and primary care.

Mr. DORN. I agree with everything Gregg has said. I would just add that of course it is important to invest in that infrastructure and we should do so.

But a lot of low-income people will not live in areas with health care centers around the corner, and no matter how much we invest in ways that are politically convenient, they will be left out in the cold if that is all we do.

In addition, low-income people will not have a choice of going elsewhere if that is all we do. We think it is critical to do both things; give your clients the choice of which providers to go to, but beef up the resources available to providers who have traditionally done a good job of servicing low-income people.

Ms. KOLKER. I would add it is always better to take a partial step rather than a whole step, but we are at the point now where there are so many problems in the system I think that we are foolish not to take this opportunity to address the provider shortages, the shortages in communities, as well as the tremendous need to provide the financial security so that if you need the health care, it is reimbursed by a third-party payer, whether public or private.

That is just a critical cornerstone of this whole effort, and without it, it falls significantly short.

Mr. DENNIS. I think of course emphasizing essential community providers is important, but that certainly is not going to provide the kind of health security alone that Medicaid or all patients require.

But it has to be interwoven into this new health care plan. Certainly essential community providers are important because they are the main providers right now for most of the Medicaid recipients so they have to be part of it.

However, that alone is just not going to solve the problem.

Mr. WAXMAN. Thank you, very much.

Ms. KOLKER. I would add one note, which is, I think at this juncture when there is such an overwhelming awareness of the magnitude of the problems that it would really be counterproductive to do something that is only partial giving us the sense that we have

addressed the problem, when in fact there are many, many aspects of the problem that have not been addressed.

Mr. WAXMAN. Thank you.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

This question is really for all four of you. All of you represent a segment of the population that has certainly been less than well served by the health care system over time.

The universal coverage promise, if you will, the promise of universal coverage is wonderful and surely will work better than what we have now.

All of you also know the struggle in terms of everything from child immunization to prenatal care to reaching the people that have generally less education and generally have not had access to the system, would each of you sum up individually and critique what is in the plan in terms of education and outreach, and then give us, go further than that, and give us your additional suggestions about what should be included?

Mr. DENNIS. I would like to start with that.

Mr. BROWN. Sure, Dr. Dennis.

Mr. DENNIS. I think there is very little mention of education and outreach. Education in terms of education is listed, is mentioned throughout the plan, but as far as significant education, for instance, even just access to the plan, how you use, particularly if an HMO is the provider, how you go about using that HMO, or even how you use the primary care doctor to access the system even if you do not have an HMO.

I think that that kind of just simple education is not even included. And with this Medicaid and low income population a lot of them do not read the mail, some of them do not even read at all, and when you have a population like that, you have to have a special way to get the information across to them.

Just having a lot of printed information just does not cut it. You are just not going to get the message across and people are not going to use the system.

That is why you have to use the essential community providers and the organizations that really know how to access their community to help get that information out.

But then, of course, there is the education having to do with preventive and just health issues. Now, that also has to be addressed. It has to be culturally sensitive, ethnically sensitive, it has to be addressed in a way that people can receive it. It cannot be in English if the person only speaks Spanish. It cannot be written, if the person cannot read it. It has to be in a form they can use that information. That is certainly critical.

Even though there is a place for education, the alliances have—it is mentioned they can provide something for education. It is really not required. And I think unless it is required and is spelled out how that education should be provided and which populations specifically require it, then I feel that of course everyone requires some education, but there are other populations that will require a lot more.

And I think unless we educate people to use the system properly, we are just going to have just a big white elephant and a huge bu-

reaucracy and people are not even going to use the system well. They will end up in the emergency room driving up the cost for everybody else in that alliance.

Ms. KOLKER. You know, I think it is ironic, I believe one report card that is mentioned in the plan, and that is a report card that will be given to, that will be provided on the plans and how well each plan is delivering the benefits it is supposed to be delivering, et cetera.

It seems to me you could take this concept and develop it at the consumer level and that there would be some way of, through public service announcements and outreach and educational materials through the schools, through the community health centers and so forth, to get individuals to think about have they met their basic health needs; are they going to the doctor; are they getting their immunizations; are they getting their mammograms, et cetera, and that you might take this sort of report card approach that has been developed for the plans and in some way make it a consumer-oriented document as well or in addition.

Mr. HAIFLEY. Congressman, I would concur in what was just said in the sense that one of the objects of this reform proposal is to open up primary and preventive care to everybody. And to the extent that efforts need to be made to make sure that plans deliver those services; that consumers or recipients know they are available and how to get access to them; that essential community providers facilitate those issues, I think that will be critical.

There is another side to it as well, in terms of the monitoring and the standards that are put in place to keep track of what the plans in fact are doing and delivering, and to make it possible for people once they are enrolled in plans to know what they are entitled to in terms of services, and to have a sense of when they are not getting the services they are entitled to and to be able to pursue the avenues that they will need to pursue to make sure they get the care that they need.

So there is both just the initial accessing of important primary and preventive services and then the whole issue of problems as they come up within plans and the education and knowledge level that everybody is going to need once enrolled in these plans.

Mr. DORN. I think the issue you raise is an absolutely critical one. Let me give you an example of why it is so vital. In the city of Boston a few years ago there was a three to one disparity in infant mortality between African-American babies and white babies, despite the presence of universal coverage of prenatal care. At that point there was a massive effort to do the kinds of services you are talking about. Outreach. And it was done very well.

Women from low income communities were used to do outreach to their neighbors and explain the importance of coming into prenatal care and helped hook them up with services to inform them about transportation and so forth.

After relatively few years—I believe it was something on the order of 3 or 4 years—the disparity went from three to one to two to one. That was not insurance. That was the kind of outreach and connective services you are talking about.

There are some real problems, I have to say, with the plan. It acknowledges the importance of these services, but does not do so

in a thorough enough way to make the kinds of difference I think that you want it to make. For example, there are some grants for enabling services. I don't recall offhand the amount. I think it is in the neighborhood of $100 million, $200 million a year. Obviously, it is not enough to make sure low-income people get transportation case management, translation.

And even those dollars are not guaranteed because the bill only provides an authorization, not mandated appropriation, unlike other parts of the bill. States have the option to pay for enabling services. They are not required to do so. And we fear many will not choose to do so.

And, finally, alliances are told they have to provide assistance when low-income people apply for subsidies but that is it. No statement of duty, no description of the level of service they have to provide, just alliances have to help people when they apply for low income subsidies, and often our clients cannot fill out the forms right or make mistakes.

And under the bill if you make mistakes, the Feds will ask you to pay some of your scarce money back to pay for those mistakes.

So we would recommend some changes. We would recommend that States be required, or we would recommend that health plans be required to provide these services to their low income enrollees; that they receive additional reimbursements for doing so; and, further, that States be held accountable for lessening the disparities.

If you say to a State you have to achieve quantified reductions in racial and economic disparities and outcomes like infant mortality, hypertension, et cetera, they will have to look for creative ways to solve those problems using the kind of mechanisms that you discuss. So I am really grateful to you for raising this issue.

Mr. BROWN. You are recommending, Mr. Dorn, that the plan require the States to develop those?

Mr. DORN. No, that when the State plans are submitted to the Federal Government, that part of that procedure should involve a negotiation with HHS to determine the maximum feasible reduction in disparities, and a plan that the States will implement to achieve those reductions.

Then, at the health plan level, health plans should be required to serve to provide these enabling services to their low income enrollees and should receive additional adjustments, additional funding to do that.

The bill says that States can, if they wish, give health plans money to provide these services. We think this issue is important enough it needs to be a mandate rather than an option.

Mr. BROWN. Should we in the health plan sort of draw a road map for them, or tell them how they need to get from here to there?

Mr. DORN. No, I don't think they have to have a road map, but just say enabling services need to be provided for all low-income people who go into plans.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

I want to thank the four of you again for your testimony, it has been very useful.

Our last panel consists of representatives of our Nation's Governors, legislatures and counties. Carol Volpe is Director of Health Policy and Legislation at the National Governors Association; Senator Allyson Schwartz is a member of the Pennsylvania State Senate and is representing the National Conference of State Legislatures; Ray Hanley is the Director of the Medicaid Program in the State of Arkansas, Chairman of the State Medicaid Directors Association, Mr. Hanley is speaking today on behalf of the American Public Welfare Association, and Irene Riley is Director of Government Affairs for the Los Angeles County Health Department and is representing the National Association of Counties.

We want to welcome the four of you to our hearing today. Your prepared statements will be part of the record in full. We want to ask you however to limit your oral presentation to no more than 5 minutes. Mr. Volpe we will start with you.

STATEMENTS OF L. CARL VOLPE, DIRECTOR OF HEALTH POLICY AND LEGISLATION, NATIONAL GOVERNORS' ASSOCIATION; ALLYSON SCHWARTZ, MEMBER, PENNSYLVANIA STATE SENATE, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES; RAY HANLEY, ON BEHALF OF AMERICAN PUBLIC WELFARE ASSOCIATION; AND IRENE RILEY, ON BEHALF OF NATIONAL ASSOCIATION OF COUNTIES

Mr. VOLPE. Good afternoon Mr. Chairman. I am Carl Volpe, Director of Health Policy and Legislation for the National Governors Association. I appreciate the opportunity to appear before you today on behalf of the Nation's Governors to discuss the impact of health care reform on Medicaid.

As Congress begins its deliberations on national health reform, the Governors are extremely interested in how Medicaid will be integrated into the new health care system. As a matter of fact, they see few issues of more importance than that in the reform debate.

Last February, the Governors developed a policy on national reform and cost containment and, as part of that, they discussed the Medicaid program. They said that if in fact some new health care system had a Medicaid-like public program, that they would like to see that program have uniformity and eligibility, stability in State financing obligations, and a service delivery system that reflects the national movement towards managed care. It is within that context that I would like to talk to you about the President's plan.

While the Governors might have preferred a greater restructuring of Medicaid, the President's proposals are generally consistent with the Governors Medicaid policy. From a State perspective the President's plan has the following advantages: Medicaid acute care services will be integrated into the same delivery system used by older Americans; States will have much more financial certainty in the growth of their Medicaid budgets. With a major restructuring of health care financing, the President's plan includes a strategy for reviewing the State financial obligations under the new system towards resolving some possible inequities among States, and there is an attempt to defray the costs of uncompensated care through a small, disproportionate share program.

We also believe the plan has several areas of improvement and I will just go over them very quickly. The first is in fact reestablishing the link to cash assistance programs. I think the Governors would prefer to see that delinking, and they think it is much better policy to have it delinked.

The Governors remain concerned about the Boren amendment. There is some relief in the President's plan from Boren for hospital reimbursement, but with regard to nursing home, there is no Boren relief and they would like to see some and are willing to work with your staff to develop some strategy that is equitable for States as well providers.

Finally, the QMB program, Mr. Chairman, you well know the States' position on that program. We believe in looking at the President's plan the complexity of the QMB program is exacerbated because of the services through the alliance. While the Governors would prefer a federalization of that program, we would be willing to talk with you and your staff and other members of the subcommittee and possibly develop some alternative strategies for making that more equitable for States and for the providers who have to bear some of the consequences of that complex system.

In conclusion, we commend the President for his efforts to simplify the program. We believe States will get much needed flexibility and predictability in program growth. The policy changes are significant and, in general, do move the Medicaid program in the right direction. However, we think more can be done. The National Governors Association is working on other alternatives. We will be working with you and your staff to improve that and, in general, we believe that there are a set of viable alternatives that may be discussed and developed over the next several months as the debate continues.

Thank you very much.

Mr. WAXMAN. Thank you Mr. Volpe.

[The prepared statement of Mr. Volpe follows:]

STATEMENT OF NATIONAL GOVERNORS' ASSOCIATION

Good morning Mr. Chairman and members of the subcommittee. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the impact of health care reform on the Medicaid program. There are few issues of greater importance to Governors than Medicaid. As Congress begins its deliberations on national health reform, the Governors are extremely interested in how Medicaid is integrated in a new health care system.

Governors' Medicaid Policy

Interim Relief. The state/federal partnership through the Medicaid program has contributed significantly to ensuring that a safety net exists for low-income individuals. This is especially important given the fragmentation that has characterized our health care system for the last thirty years For at least the last five years, however, the nation's Governors have been calling for relief from Medicaid mandates. The administrative and financial burdens resulting from general medical inflation, Medicaid's individual entitlement nature, and the proliferation of unfunded federal mandates have created havoc with state budgets. Medicaid has had a profound effect on state budgets to the point that other programs have suffered. Medicaid has grown in both absolute and relative dollars. The Medicaid program has increased in excess of 20 percent annually for the last five years, but that growth also has represented a greater percentage of total state spending. In 1986 Medicaid represented about 10 percent of total state spending; by 1992 it was 17 percent. And while states averaged 17 percent of total spending, twelve states had Medicaid spending above 20 percent and some were as high as 27 and 34 percent.

Overall, state Medicaid spending is now higher than that for higher education, which is only at 11 percent of spending. By 1995 Medicaid is projected at 25 percent of state spending, while state spending on elementary and secondary education is only projected to be 22 percent. The growth in Medicaid, particularly during 1991 and 1992, was a major reason why states increased taxes by $25.6 billion over this two-year period. It is no wonder that states have had to cut spending and raise taxes to keep up with the needs of education and economic development.

In calling for relief, the Governors have focused on more flexibility in setting institutional reimbursement rates, a rollback to options of service and eligibility mandates, and the opportunity to establish cost containment approaches through managed care without the onerous statutory

burdens that currently exist in the program. Although this hearing is about Medicaid and national health reform, Governors would still like to have more flexibility in the short run to make these adjustments as we get ready to implement more comprehensive reform.

National Reform. On November 4, Raymond Scheppach, the executive director of the National Governors' Association (NGA), appeared before you on behalf of Governors to discuss the role of states in national reform. He talked about the Governors' policy supporting the development of a national health care system that recognizes both the importance of federal uniformity in health reform and the essential roles and responsibilities of states in the administration and delivery of care. The Governors also believe that strong cost control systems are essential for any national health reform strategy.

When that policy was adopted last February, the Governors called for the full integration of public programs, such as Medicaid, into the new system of care. They said if the new system had a Medicaid-like public program, that public program must have:

- uniformity in eligibility;
- stability in state financing obligations; and
- service delivery systems that reflect the national movement toward managed care.

The Governors support a reform strategy for acute care that, within a managed competition model, eliminates our current two-tier health system. Specifically, Medicaid beneficiaries should receive care through alliances. Although the Governors understand the need for additional services for special populations, they do not support Medicaid-type mandates financed by states for additional services beyond a core benefits package. They believe that a streamlined and efficient public program that is integrated into a comprehensive health care system would obviate the need for complex and costly waivers. Finally, they support the full integration of Medicare into a new health care system, as long as the benefits package is adequate.

It is within the context of that policy, Mr. Chairman, that I address the Medicaid proposals in the President's health plan. At the end of my testimony, however, I would like to revisit the broader issues of Medicaid restructuring in national health reform.

Governors' Reaction to President Clinton's Health Plan

The President has chosen to maintain the general Medicaid structure in his health reform package. While the Governors might have preferred a greater restructuring of the program, the President's proposals are generally consistent with the Governors' Medicaid policy. From a state perspective, the President's plan has the following advantages.

1. **Medicaid acute care services will be integrated into the same service delivery system used by all Americans.**

The Governors support the integration of the cash and noncash categorical populations into alliances. This unitary acute care service delivery structure should dramatically reduce the incentive for a two-tiered health system that results from our current Medicaid program. As we have seen in the Medicaid program, some education and outreach will be needed as Medicaid beneficiaries and others move from a fee-for-service environment into a network environment. Care must be taken that this change occurs as smoothly as possible without sacrificing quality and access to care.

2. **States will have much more financial certainty in the growth of their Medicaid budgets.**

Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) beneficiaries will receive services in the guaranteed national benefits package through regional alliances. With federal matching funds, states will be required to pay alliances a per capita amount for each beneficiary. And that per capita payment will increase at a predetermined amount each year. This approach gives states significant stability in a part of their Medicaid budget and is supported by the Governors.

There has been some discussion about the adequacy of the per capita payment to purchase health care through alliances. The calculation is somewhat complex, but we understand that it is equal to 95 percent of the average Medicaid expenditures made for services that are in the national guaranteed benefits package for these beneficiary groups.

The administration believes that this per capita payment will be sufficient to cover the premium cost for AFDC and SSI recipients. In fact, it has said that the per capita payments may

be greater than the average weighted premium in some alliances. Although we have not seen data, their arguments may have merit. First, while it is true that Medicaid reimbursement rates have been lower than those of other health care payers, reimbursement rates have improved in recent years. Second, the per capita payment is based not solely on rates, but on rates and utilization, and Medicaid beneficiaries may have higher utilization patterns than other populations. Finally, Medicaid beneficiaries have a greater tendency to seek care in high-cost settings (e.g., emergency rooms). This behavior is seen much less frequently in the general population and should contribute to a higher per capita rate. Because the per capita calculation is based on the existing behavior of Medicaid beneficiaries, the administration may be correct in its assumptions. However, further analysis will be needed to ensure that these assumptions are correct. Governors are concerned about the consequences should growth rates be artificially low.

Maintenance of Effort Payments. States will be required to make lump sum payments for Medicaid services that previously had been provided to the noncash categorical populations. Like the cash categorical populations, the payment is based on expenditures for Medicaid services in the guaranteed national benefits package. This strategy holds states harmless from unpredictable changes that have been the hallmark of Medicaid in recent years.

3. **With a major restructuring of health care financing, the President's plan includes a strategy for reviewing the state financial obligations under the new system toward resolving possible inequities among states.**

The President's plan requires states to make payments in support of national health reform based on current Medicaid spending patterns and using current federal Medicaid matching percentages. Because of the significant differences among states in Medicaid match and program characteristics, this strategy could punish states with more generous programs by requiring of them a greater financial maintenance of effort. The extent of this perceived inequity is complicated by real differences among states in their fiscal capacity to support health care. The issue requires reasoned study before changes are made. The Governors support the President's decision to have a commission review the methodology used to calculate state financial obligations.

4. **The President has enhanced institutional long-term care options and proposed a new community-based long-term care program that gives states significant flexibility to meet the individual needs of beneficiaries while protecting the financial exposure of both states and the federal government.**

In general, the Governors can support the incremental changes to Medicaid long-term care in the President's plan. They support the state option to increase the protected assets limit from $2,000 to $12,000. The requirement for establishing medically needy programs affects about fourteen or fifteen states, and because this is a new mandate, it may have significant fiscal impacts on these states. NGA policy opposes unfunded Medicaid mandates. As we get a better understanding of the impact of this mandate, we will keep the committee informed.

New Community-Based Care Program. The President's plan creates a new joint state and federally financed community based long-term care program for persons with significant functional impairments. The Governors support community-based alternatives to institutional care, and the plan contains several provisions, including this one, consistent with their position. Not only does the plan increase the availability of community-based long-term care, but states have significant flexibility in the program's design to meet the needs of beneficiaries. Although this program requires state matching funds, the match rate is favorable to states. States should be able to expand some of their state-financed community-based initiatives through this program.

Because of the limitations on federal spending, the President has tried to construct the program so that states' financial obligations are equally limited. The Governors strongly support this practice. Limitations on spending must be applied equally to states and the federal government However. Governors are concerned that despite of drafting efforts, the courts might consider this program an individual entitlement to services.

5. **The President has recognized the need for retaining programs to help defray the cost of uncompensated care.**

Disproportionate Share Hospital Programs. The Governors support the continuation of a disproportionate share hospital program as part of the President's plan. Despite the best efforts to

provide universal coverage, the Governors believe that there will remain a small part of the population (for example, undocumented aliens) that will continue to seek care at hospitals, most likely public hospitals, for which there will be little or no compensation. Without such a program, the cycle of cost shifting to the paying population will continue. In addition, the Governors support a stronger federal financial response to the increasing health care burden on states resulting from undocumented aliens.

Areas of Improvement

There are several aspects of Medicaid where the Governors would suggest program modifications.

Re-establishing the Link to Cash Assistance Programs. Since the mid-1980s, Congress has enacted Medicaid legislation that has delinked Medicaid from its historic ties to cash assistance programs. Delinking public health care programs from public cash assistance programs is good public policy. Unfortunately, by requiring per capita payments for each AFDC and SSI beneficiary, states would be required to consider health care costs when considering policy decisions in the AFDC and SSI programs. The Governors would support an approach that delinks these programs from Medicaid.

Boren Amendment. Mr. Chairman, the President's plan gives states relief from Boren lawsuits for hospitals but fails to do so for nursing facilities. States have suffered long enough from the judicial interpretations of the last decade. The Boren Amendment was intended to help states in setting reimbursement rates, not harm them. The Governors believe something should be done regarding Boren as part of health reform. They are aware that the administration is moving ahead to develop regulations for Boren. Although this effort should be commended, the administration is bound by the parameters of the statute and the statute gives states little flexibility. A repeal of the Boren Amendment may be no help to either providers or states. Rather, a coalition of states has proposed a series of "safe harbors" that would give states some protection while protecting the industry. These or other equitable alternatives could be helpful to states and should be included in the reform package.

Qualified Medicare Beneficiaries and Related Programs. The President has chosen to continue the Qualified Medicare Beneficiary (QMB) program and related programs, including the program for individuals who are dually eligible for Medicaid and Medicare. The Governors believe that this decision requires further review. Members of Congress are well aware of enrollment problems with the QMB program. But enrollment problems are just the tip of the iceberg. The administrative complexity associated with reimbursement is nothing short of astounding for both providers and states. When a claim is made, the provider must first bill Medicare. Following the Medicare decision, the claim is then sent to Medicaid for residual reimbursement.

Unfortunately, the administrative inefficiencies for states are greater under the President's plan. States are now able to make the recalculation from Medicare to Medicaid because they have existing Medicaid claims payment systems. However, states will have no need for such claims payment systems for acute care services under the President's plan because they will be making a predefined per capita payment for the cash assistance populations and have no claims payment responsibilities for the noncash categorical population. States would be left with maintaining acute care claims payment systems solely for these "crossover" claims. This is quite an expensive proposition for both Medicare and Medicaid, especially because of the new Medicare prescription drug benefit. Finally, the problem with crossover claims is compounded when the beneficiary is in a health maintenance organization and even more problematic when the beneficiary is a dual eligible recipient and is in both a Medicare and Medicaid HMO.

The Governors support the federalization of this program. If it is not federalized, they would like to work with subcommittee staff to explore other options.

Conclusion

The President must be commended for his efforts at simplifying the complexities of Medicaid through his proposed changes. The Medicaid eligibility categories are greatly simplified. AFDC and SSI recipients will have access to the same service delivery structure as do other citizens. And

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states will get long-needed predictability in program growth. The Governors believe that these policy changes are significant and move the Medicaid program in the right direction.

However, these are incremental program changes. While the public policy objectives of Medicaid are sound, the program was designed as a critical safety net in a fragmented and inequitable health care system. As the nation begins its efforts to revamp the entire U.S. health care system, an unprecedented opportunity exists to re-define health care for poor people, as well as people with chronic conditions and disabilities, so that their care is integrated and seamless.

Mr. Chairman and members of the subcommittee, I cannot put before you today the Governors' vision for such a system. However, the National Governors' Association looks forward to working with you and others to develop viable reform options. We hope to offer you some alternatives in the near future. As we begin that process, we plan to consult the staff of this subcommittee and other congressional committee staff for guidance and advice.

The opportunity for major change is upon us and should not be squandered. The nation's Governors are key stakeholders in ensuring that any new health reform system includes and integrates health care for the poor. They look forward to working with this subcommittee as this debate evolves and hope that a true state/federal partnership can be formed through health care reform.

Thank you for the opportunity to appear before you today. I will be happy to answer any questions.

Mr. WAXMAN. Senator Schwartz.

STATEMENT OF ALLYSON SCHWARTZ

Ms. SCHWARTZ. Thank you, Mr. Chairman. It is an honor to be here before you and to speak on behalf of the National Conference of State Legislatures I am representing today. I serve on the Health and Welfare Committee in the Pennsylvania Senate and have worked on a variety of health care issues in my first term in office, which began in 1990.

I represent the National Conference of State Legislatures. Our goal is to work with you to craft a health care reform plan that does assure health care coverage for all residents of the United States, which allows for Federal guidance, a strong, meaningful role for the States in a program design and implementation for equity to the States, and for a strong, reliable fiscal base to the plan.

We have not endorsed a particular plan, but we certainly do applaud the leadership provided by the President and others in crafting this health care reform plan and agree with his basic principles. My written testimony goes into a variety of detail. I will highlight a few areas that we are particularly concerned about.

The President's reform represents a unique opportunity to fully integrate the acute care reform portion of Medicaid into this new comprehensive health care reform package for all Americans completely decoupling the eligibility for health care services from eligibility for the Federal case assistance programs.

The Clinton proposal would fully integrate the non-cash Medicaid recipients into the system and partially integrate individuals receiving Aid to Dependent Children, AFDC, and SSI into the system. We believe this is movement in the right direction. However, we would go further and support full integration to include all categorically eligible individuals.

Under the President's plan, State-mandated benefits will be replaced by the standard set of benefits package by the Federal Government. If the acute care portion of the Medicaid program is fully integrated into the new system, some individuals will receive less coverage than they are eligible for.

You heard a great deal about this today; about loss in possible benefits. However, the proposal also says that States would be required to provide residual Medicaid coverage for categorically eligible individuals. We are very concerned about this requirement. The approach creates inequities in the health care system. Similarly situated individuals would not receive these services regardless of their needs.

We heard from the previous panel about necessary Medicaid optional services that are provided by a number of States. We believe they ought to be continued but that the way to do this is through a comprehensive standard benefits package for all Americans with less distinction. If that cannot be done, then we would say that any add-ons must be done with assurances to prevent the fragmentation that could possibly happen.

Moving on to another area, children with special needs. And the intention of the health care plan is to make sure that children covered previously under EPSDT don't lose their benefits. We endorse

this concept but are very concerned about some of the structure in the plan.

We believe that the program could be easier to administer if the income eligibility limits were standard and if applied to all children with income eligibility levels of the same. It would be established across the board. We would hope that children would be enrolled in an accountable health plan with the rest of their family and would be automatically enrolled in special children's programs and their household become eligible and their care provided through the entire plan.

In Pennsylvania, we have had some experience with this kind of add-on children's program in the program called CHIP, Children's Health Insurance Program, where we have used 2 cents of the cigarette tax dollars to provide services to uninsured children, and we too set up an elaborate eligibility formula so that we would target both the youngest children and the poorest children in the State.

We have found in the short time of implementing the program, that the eligibility criteria themselves are confusing and a potential deterrent to enrollment. They also require us to provide specialist outreach to try and identify these children and try and get them enrolled in the program.

In some ways, the elaborate eligibility runs counter to the goal which is universal coverage, administrative simplification, and getting services that are needed by children to those children. So I suggest that you learn from our experience and hopefully define more broadly those services to children who are in need.

One other thing, the maintenance of effort on the part of States. We are concerned here too that while we agree with maintenance of effort and believe that there should be a State sharing in the cost of health care reform, we want to make sure that in fact States that have been generous in their benefits do not get penalized for that, that there is fairness and equity across the States.

I will end by saying that we look forward to working with the Federal Government in making sure that we have universal coverage, that we don't establish too many differentiations and fragmentations and create an administrative burden on the States that direct health care dollars to administration, not to health care services and that we assure there is adequate funding for all these programs; that we don't mislead the State, the Federal Government, or the American people into believing there will be a broad benefits package, they will have security and in fact there won't be enough money to do that.

I know that you share that concern as well, and we want to work with you in making sure that we can get all of these services to all of our people.

Thank you.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 684.]

[The prepared statement of Ms. Schwartz follows:]

TESTIMONY OF SENATOR ALLYSON SCHWARTZ

ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

MY NAME IS ALLYSON SCHWARTZ. I AM A MEMBER OF THE PENNSYLVANIA STATE SENATE AND CHAIR THE STATE GOVERNMENT COMMITTEE. TODAY, I AM SPEAKING ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL)[1], WHERE I SERVE AS A VICE CHAIR OF THE HEALTH COMMITTEE.

MY TESTIMONY IS BASED ON NCSL POLICY WHICH REFLECTS OUR DEDICATION TO PRESERVING A STRONG FEDERAL SYSTEM OF GOVERNMENT, PROTECTING OUR NATION'S VULNERABLE POPULATIONS, DEVELOPING CREATIVE, CONSTRUCTIVE DOMESTIC INITIATIVES, AND FORGING AN EFFECTIVE STATE-FEDERAL HEALTHCARE REFORM PARTNERSHIP. OUR GOAL IS TO HELP CRAFT A HEALTH CARE REFORM PLAN THAT PROVIDES: (1) HEALTH CARE COVERAGE FOR ALL RESIDENTS OF THE UNITED STATES; (2) FEDERAL GUIDANCE WITH A STRONG, MEANINGFUL ROLE FOR STATES IN PROGRAM DESIGN AND IMPLEMENTATION; (3) EQUITY FOR AND BETWEEN STATES; AND (4) A STRONG, RELIABLE FISCAL BASE.

WHILE NCSL HAS ENDORSED NO SPECIFIC PLAN OR APPROACH, NCSL APPLAUDS THE LEADERSHIP THAT PRESIDENT CLINTON HAS PROVIDED IN CALLING FOR HEALTH CARE REFORM AND HIS EFFORTS TO GUARANTEE LIFELONG HEALTH CARE COVERAGE. THE SIX BASIC PRINCIPLES OF THE PRESIDENT'S PLAN; SECURITY, SIMPLICITY, SAVINGS, QUALITY, CHOICE, AND RESPONSIBILITY, ARE CONSISTENT WITH NCSL'S POLICY. I AM PLEASED TO BE HERE TODAY TO DISCUSS THE MEDICAID PROVISIONS IN PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL.

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1 NCSL REPRESENTS THE LEGISLATURES OF THE FIFTY STATES, ITS COMMONWEALTHS, TERRITORIES AND THE DISTRICT OF COLUMBIA.

Full Integration of Medicaid Acute Care Services

The President's reform effort presents a unique opportunity to fully integrate the acute care portion of Medicaid with the new comprehensive health care reform program, completely decoupling eligibility for health care services from eligibility for federal cash assistance programs.

President Clinton's proposal would fully integrate the noncash Medicaid recipients into the system and partially integrates individuals receiving Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) into the system. We believe this is movement in the right direction, however; we support full integration which would include categorically eligible individuals.

Supplemental/Residual Benefits

Under the President's plan, state mandated benefits will be preempted and replaced with a set of standard benefits established by the federal government. As a result, many of us will receive less coverage or different coverage than we currently receive under our existing health insurance packages. Similarly, if the acute care portion of the Medicaid program is fully integrated into the new system, some individuals will receive less coverage than they are eligible to receive today under the Medicaid program in their state. For example, if the Medicaid program in the state where an individual resides covers optional services not included in the Administration's standard benefit package, they in effect would lose those benefits.

It is likely that those of us participating in regional or corporate alliances, that wish to continue to be covered for services not included in the standard benefit plan, will be able to obtain that coverage through either supplemental insurance or through out-of-pocket expenditures. Under the Administration proposal, noncash Medicaid recipients would lose eligibility for "residual" Medicaid coverage and would have to obtain additional coverage in the same manner as other participants in the regional or corporate health alliances.

Individuals who are categorically eligible for Medicaid, by virtue of their eligibility for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI), would continue to be eligible for and states would be required to provide, residual Medicaid coverage. We are concerned about this requirement. This approach creates inequities in the new health care system. Similarly situated individuals would be eligible for different health care coverage and services based solely on their eligibility to receive federal cash assistance through AFDC or SSI. If the comprehensive, standard benefit package fails to provide adequate coverage for certain individuals, the eligibility for supplemental coverage should be standard and the financing should be clearly set out.

There are certainly Medicaid optional services that are extremely beneficial to current Medicaid recipients. These benefits are likely to prove beneficial to other low income and/or disabled participants in the regional or corporate health alliances. NCSL believes that we need to focus on identifying services, not covered in the standard benefit package, that are critical to ensure participation of low income and disabled individuals regardless of their source of income or status with respect to federal cash assistance programs. This is an area where

STATES, IN CONCERT WITH LOCAL GOVERNMENTS, REGIONAL HEALTH ALLIANCES, HEALTH CARE PROVIDERS, LOW-INCOME AND DISABLED INDIVIDUALS, AND ACCOUNTABLE HEALTH PLANS, SHOULD WORK CLOSELY TOGETHER TO DEVELOP A WORKABLE SOLUTION. SUCH AN APPROACH WOULD BE MORE IN THE SPIRIT OF THE ADMINISTRATION'S OVERALL REFORM STRATEGY THAT STRIVES TO ESTABLISH A LEVEL OF UNIFORMITY AND EQUITY WITHIN THE SYSTEM.

PROGRAM FOR CHILDREN WITH SPECIAL NEEDS

THE ADMINISTRATION HAS PROPOSED A NEW CAPPED ENTITLEMENT PROGRAM THAT WOULD PROVIDE MEDICALLY NECESSARY SERVICES, NOT INCLUDED IN THE STANDARD BENEFIT PACKAGE, EXCLUDING LONG TERM CARE SERVICES, TO CHILDREN IN CERTAIN LOW-INCOME HOUSEHOLDS. THE PROGRAM WOULD BE 100 PERCENT FEDERALLY FUNDED. STATES WOULD BE RESPONSIBLE FOR DETERMINING ELIGIBILITY. WE ARE CONCERNED ABOUT THE COMPLICATED ELIGIBILITY CRITERIA FOR THE CHILDREN'S PROGRAM. WE ARE ALSO CONCERNED ABOUT THE DESIGNATION OF "ESSENTIAL COMMUNITY PROVIDERS" AS THE ENTITIES BY WHICH CHILDREN WOULD ACCESS THIS SPECIAL PROGRAM.

WE BELIEVE THAT THE PROGRAM WOULD BE EASIER TO ADMINISTER IF THE INCOME ELIGIBILITY LEVEL WAS STANDARD AND IF IT APPLIED TO ALL CHILDREN WITHIN THE INCOME ELIGIBILITY LEVEL ESTABLISHED. WE ALSO HOPE THAT MOST CHILDREN WILL BE ENROLLED IN AN ACCOUNTABLE HEALTH PLAN WITH THE REST OF THEIR FAMILY AND WOULD BE AUTOMATICALLY ENROLLED IN THE SPECIAL CHILDREN'S PROGRAM IF THEIR HOUSEHOLD WAS INCOME ELIGIBLE. AGAIN, THIS ENROLLMENT EFFORT WOULD BE SIMPLER IF THE INCOME ELIGIBILITY LEVEL WAS THE SAME FOR CHILDREN OF ALL AGES. IF THE CHILDREN ARE TO BE ENTITLED TO THESE SUPPLEMENTAL BENEFITS, THE FEDERAL FUNDING SHOULD NOT BE CAPPED.

Maintenance of Effort

States will be required to make premium payments on behalf of individuals receiving benefits under AFDC and SSI. These per capita payments will be based on the states' Medicaid expenditures for the benefits included in the federally established standard benefit package for the year just prior to state implementation of the Health Security Act. Increases in subsequent years will be based primarily on growth in program enrollment. States will be required to contribute 95 percent of the per capita expenditures for AFDC and SSI recipients to the regional alliances.

The noncash Medicaid recipients will be fully integrated into the regional alliance system. States will be required to contribute 100 percent of their expenditures on the standard benefit package to these individuals in the year prior to implementation of the Health Services Act. This requirement penalizes states that made the greatest effort to expand Medicaid coverage over the last several years, by building this larger financial commitment into their maintenance of effort baseline and continuing this commitment over the long term. This requirement takes a current law Medicaid option, makes it a mandate, and continues it indefinitely. NCSL urges reconsideration of this requirement.

NCSL does not oppose maintenance of effort requirements, however; it is critical that the requirements are fair. We oppose being locked into "optional" programs currently in place and we oppose maintenance of effort requirements that penalize states that have made a concerted effort to: (1) extend coverage to the uninsured by using available Medicaid eligibility options; (2) provide a

LARGE ARRAY OF OPTIONAL SERVICES TO ELIGIBLE INDIVIDUALS; OR (3) HAVE ESTABLISHED EFFECTIVE COST CONTAINMENT STRATEGIES IN THEIR MEDICAID PROGRAM. WE LOOK FORWARD TO WORKING WITH YOU ON THIS IMPORTANT ISSUE.

LONG TERM CARE

NCSL POLICY STATES THAT LONG TERM CARE SHOULD CONTINUE TO BE JOINTLY FUNDED BY THE STATES AND THE FEDERAL GOVERNMENT AND ADMINISTERED BY THE STATES AND THAT INNOVATIONS TO INCREASE THE COST EFFECTIVENESS OF AND ACCESS TO LONG TERM CARE SERVICES SHOULD BE EXPLORED. NCSL SUPPORTS A GREATER EMPHASIS ON HOME AND COMMUNITY-BASED CARE.

o NEW HOME AND COMMUNITY-BASED CARE PROGRAM

THE PROPOSED HOME AND COMMUNITY-BASED CARE PROGRAM INCLUDES MANY ELEMENTS SUPPORTED BY NCSL. THE PROGRAM, A NEW STATE OPTION, IS DESIGNED TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO SEVERELY DISABLED INDIVIDUALS AND IS A CAPPED ENTITLEMENT TO STATES. IT IS IMPORTANT TO NOTE HERE THAT STATES, NOT INDIVIDUALS, ARE ENTITLED TO THIS FUNDING. THE PROGRAM IS, IN EFFECT, A BLOCK GRANT TO STATES, WHERE THE STATE FUNDING IS NOT SUBJECT TO THE CONGRESSIONAL APPROPRIATIONS PROCESS.

IT WILL BE DIFFICULT TO EXPLAIN TO INDIVIDUALS THAT THEY ARE NOT ENTITLED TO SERVICES AND THAT THE FUNDS ARE LIMITED. THERE IS TREMENDOUS PENT UP DEMAND FOR THESE SERVICES. HOWEVER, THIS IMPORTANT PROGRAM OPTION PROVIDES A WONDERFUL OPPORTUNITY FOR STATES TO TRY INNOVATIVE APPROACHES TO PROVIDING HOME AND COMMUNITY-BASED SERVICES TO SEVERELY DISABLED INDIVIDUALS.

NCSL is particularly pleased with the level of state flexibility in the President's proposal. There will be considerable pressure applied to load this program up with a number of state requirements. NCSL urges you to resist these efforts and to retain the level of state flexibility provided for in the President's proposal.

o Medicaid Long Term Care

The Administration has proposed to: (1) require states to establish a medically needy program for long term care services; (2) increase from $30 to $70 the personal care allowance; and (3) to permit states to raise the level of protected assets for single individuals from $2,000 to $12,000. NCSL opposes the new mandate requiring the establishment of a medically needy program. We support the option to increase the resource limit and to increase the personal care allowance to $70. The President has committed to covering the additional cost to states that would occur as a result of raising the personal care allowance. We are very supportive of federal funding for this mandate.

Under current law, Medicaid recipients under age 22 and over age 65 are eligible to receive services from Institutions for Mental Diseases (IMDs). It appears that under the Clinton proposal, the noncash Medicaid recipients that are being integrated into the regional alliances would retain eligibility to all Medicaid long term care services, except this one. This would represent a significant change in the Medicaid long term care program. We hope this oversight will be corrected before the President's proposal is officially introduced in Congress.

o **Long Term Care Integration Option**

NCSL is studying the provisions of the law that would permit states to integrate all long term care programs into one. It is an intriguing proposition. We are concerned that individuals would no longer be entitled to long term care services; however, since the program funding would be capped, we would be unable to support the program if eligible individuals would be entitled to services.

Disproportionate Care Payments

The President proposes to repeal Medicaid disproportionate share hospital payments, but establishes a new $800 million program that makes payments to hospitals that serve vulnerable populations. The Medicaid disproportionate share program was substantially reduced in the 1993 budget legislation; however, we believe this program would represent a substantial reduction from that level. We hope this new program will adequately address the costs incurred by hospitals providing care to uninsured individuals under the President's reform program.

Boren Amendment

The President would repeal the Boren Amendment as it applies to hospitals, but the amendment would remain in effect as it applies to nursing facilities, intermediate care facilities for the mentally retarded and the developmentally disabled (ICF/MRs), and Institutions for Mental Diseases (IMDs). NCSL

believes that states should set reimbursement rates under Medicaid. We support the repeal of the Boren Amendment in its entirety.

Qualified Medicare Beneficiaries (QMBs)

The President's proposal retains the requirement that states continue to pay the Medicare premiums, copayments, deductibles, and coinsurance for low income Medicare beneficiaries or Qualified Medicare Beneficiaries (QMBs). As a result of proposed Medicare changes, state costs associated with these individuals will rise. The President proposes to add a prescription drug benefit to the Medicare program. This will raise Part B premium costs by $11 per month. In addition, there will be a $250 deductible and a 20 percent coinsurance requirement on the prescription drug benefit. States will be required to pick up these costs for QMBs. NCSL continues to oppose the mandatory state coverage of QMBs.

Coverage for Undocumented Individuals

NCSL supports universal coverage for all residents of the United States and its territories. We understand the public policy concerns regarding coverage of undocumented individuals; however, we feel strongly that the federal government should address this problem squarely. As states, we have no ability or authority to control the flow of undocumented individuals and must provide health care to these persons when they appear at the hospital or clinic door. We should not be left unassisted or inadequately assisted, to provide health care to them.

Certain states will be very adversely affected due to the large numbers of undocumented individuals within their borders. While some funding will be set aside to reimburse hospitals for care they provide to uninsured individuals, and emergency care through the Medicaid program will continue to be available, a more adequate and specific response to this problem is essential.

Conclusion

In summary, NCSL supports:

- Universal coverage for all residents of the United States and its territories;
- Full integration of the acute care portion of Medicaid and a complete decoupling of eligibility for health care services from eligibility for AFDC, SSI or other federal cash assistance programs;
- Continued eligibility for IMD services for low income individuals that are not eligible for AFDC or SSI;
- Fair and equitable maintenance of effort requirements for states;
- Repeal of the Boren Amendment as it applies to all providers;
- Adequate funding for services to which individuals are entitled; and

- o CONTINUED FLEXIBILITY IN THE PROPOSED HOME AND COMMUNITY-BASED CARE PROGRAM.

I APPRECIATE THIS OPPORTUNITY TO SHARE OUR VIEWS ON THE MEDICAID PROVISIONS OF PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL. OUR GOAL IS TO BE ACTIVE PARTICIPANTS IN DEVELOPING A COMPREHENSIVE HEALTH CARE REFORM STRATEGY BASED ON FOUR PRINCIPLES: (1) UNIVERSAL COVERAGE; (2) A STRONG ROLE FOR STATES IN PROGRAM DESIGN AND IMPLEMENTATION UNDER GENERAL FEDERAL GUIDANCE; (3) EQUITY FOR AND BETWEEN STATES; AND (4) A FIRM FISCAL FOUNDATION. NCSL LOOKS FORWARD TO WORKING WITH YOU TO ACCOMPLISH THESE GOALS OVER THE COMING MONTHS.

THANK YOU AND I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Mr. WAXMAN. Mr. Hanley.

STATEMENT OF RAY HANLEY

Mr. HANLEY. Thank you, Mr. Chairman. It is a pleasure to be here today to represent APWA before the committee. APWA has been around for 63 years and its mission has been to advocate for social welfare policy improvement and changes, and certainly health care reform comes under that heading.

The State Medicaid Directors Association, of which I am the chairman, is an affiliate of APWA. Neither APWA nor the State Medicaid directors have taken any position in support or opposition of any of the health care plans including the President's. We are open to analyzing all of those that are put forward. Back to 1988, APWA has supported the concept of universal coverage, put forth a plan called Access which called for expanding Medicaid coverage to everybody below 75 percent of poverty, allowing those to 200 percent of poverty to buy into Medicaid, doing away with all the categorical boxes and confusions that are incumbent with Medicaid now.

While the President's plan is not that direction, the alliance concept certainly is one that we can support because it does lead toward universal coverage. The idea of Medicaid buying recipients into the alliances is no different than what we do today. We buy in Medicare part B low-income recipients under COBRA for those that lose their employment, AFDC recipients that go to work. This is something that we already do, so it is not much of a departure.

The 100 percent federally funded wraparound Medicaid benefit for eligible children, we certainly support that. There is going to be a problem, as previous witnesses have said, some kids that are getting services now under some of these expanded services will likely not have that the way the program is designed. That is a concern.

The supplemental services that we are talking about, transportation, some of the extended therapy services, that is something that Medicaid has a lot of experience with and believes in. There has been a lot said about the availability of primary care providers and I can tell you that in a State like Arkansas, the delta, some rural areas in the Ozarks, simply giving someone one of these cards will not give them access to health care because there are no physicians available, so we will have to do something about the primary care infrastructure.

The role for States, certainly APWA supports a major role for the States in health care reform. It is the States that have the experience serving 30 million low-income people, eligibility determination, insurance benefit coordination, outreach, fraud and abuse control—simply relying on some of the systems that we have developed, the State and Federal Government has a tremendous investment in the Medicaid management information systems.

We have the most sophisticated kinds of processing systems in the industry that capture all this information that can be used to create these quality report cards that are going to be called for in the plan. For instance, in my State, every recipient already has a plastic ID card. The billing is done by the physician or provider, point of sale. It takes about 20 seconds to verify eligibility, other

income. We pay the provider within 3 days of seeing the recipient. No other payor program can touch that performance.

Other States are coming behind us with this kind of approach. We operate at an overhead of less than 4 percent. We are real proud of that. This kind of technology can be picked up and used, I think, in the reform effort.

Long-term care, certainly Medicaid and the States, are still going to have to operate the long-term care system and I suspect the wraparound programs for special needs children. Diversity—we don't want to lose sight of that. Certainly Los Angeles and rural Mississippi and west Texas have far different needs. Managed care is the norm in Wisconsin, southern California.

In Arkansas, the two largest and only HMO's recently merged. Between the two, they only cover 47,000 lives. Eligibility determination—somebody is going to have to do that. Certainly the States are prepared to lend their support to that under the reform program.

Last, long-term care is something that probably tops the list of millions of Americans' concerns, how they are going to pay for long-term care if they need it. The States are certainly interested in lending their support to creating a rational, long-term care program, and we look forward to being involved and perhaps participating in the hearing you are going to have at a later date on that.

Thank you.

Mr. WAXMAN. Thank you.

[The prepared statement of Mr. Hanley follows:]

STATEMENT OF AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. Chairman, I appreciate the opportunity to speak today on behalf of the American Public Welfare Association on the impact of President Clinton's health care reform proposal on lower income Americans, including Medicaid recipients.

The American Public Welfare Association is a 63 year old nonprofit, bipartisan association of agencies and individuals concerned with social welfare policy and practice. The Association's National Council of State Human Service Administrators represents the state cabinet–level officials charged with administering programs on behalf of low–income individuals and families. The State Medicaid Directors' Association is an APWA affiliate.

Neither APWA, nor the State Medicaid Directors' Association, has taken a formal position on the administration's health care reform proposal. We have, however, spent many hours studying and analyzing various proposals designed to improve the availability of quality health care for all Americans, and, beginning in 1988, have made suggestions for reform. It is from that perspective, and the perspective of one who actually administers a Medicaid program, that I speak today.

First, we support the principle of universal coverage. In 1988 APWA issued a special report entitled Access that recommended employer-based coverage for those who work and expansion of the Medicaid program to cover all non-working individuals and dependents with family incomes below 75% of the federal poverty level. If recommended that persons with incomes above that level, but below 200% of the federal poverty level, enroll and pay premiums on a sliding scale. We argued then that the Medicaid expansion would be equitable, because all lower-income Americans would be treated the same way. The President's proposal would provide coverage for non-working lower-income Americans through the alliances, with the federal and state governments assisting in the cost of the premiums. While a different approach to universal coverage from our Medicaid expansion proposal, the result is the same, and we would support it.

I should add, Mr. Chairman, that several of my fellow Medicaid directors have expressed approval of the subsidized premium approach, because lower-income patients are not readily identifiable as poor. One of the original goals of the Medicaid program was to give lower income persons public health insurance so they could buy care from mainstream providers. Buying recipients coverage through the alliances would not be any different from what we do now when we purchase Medicare Part B for senior citizens, or pay COBRA premiums for persons who lost their jobs, or pay the employee's share of health insurance, under the Family Support Act, for AFDC recipients who go to work.

We support the 100% federally funded "wrap around" Medicaid benefit for eligiblechildren. Section 4222 of the draft bill would extend this benefit to children who are now eligible for Medicaid including as well those not now receiving cash assistance, i.e., children eligible under the new percentage of federal poverty standards enacted after 1987, as well as those who qualify for Medicaid under the "medically needy" option. These children would be entitled to coverage for supplemental benefits -- those not included in the standard benefit package --except long-term care. Some of these supplemental benefits, such as transportation to and from medical appointments and specialized treatment centers (like Easter Seal programs, for example), are integral components of the child's care plan. It is critical that federal funding for this coverage continue.

We support the various proposals to enhance the availability of primary care providers. At several points in the draft bill there are provisions designed to maintain or increase primary care resources. Subtitle H of Title VII authorizes a tax credit for primary care providers serving in a health professional shortage area. Title III, the public health initiatives, authorizes funding for community and migrant health centers, and for school-based health services, and requires that a greater share of federal funding for medical education be directed at primary, rather than speciality, care. Those of us who administer Medicaid programs, especially in states like Arkansas, with a substantial number of rural areas, know that enhancements to primary care providers are essential if we are to be able

to serve all in need. . health security card is of little use when there is no physician available to see you.

We support a continuing major role for the states. The administration's plan envisions a major role for state governments. States would certify the health plans, assure a health plan is solvent, assist the alliances in determining eligibility for premium discounts or subsidies, and, if we wish, assume even more responsibility by becoming a single payer state or a regional alliance. Today state governments operate Medicaid programs serving more than 28 million people a year. They also operate state employee benefit programs, and, in some states, state or state/local insurance programs for non-Medicaid eligible children or lower-income adults. We are experienced in income eligibility determinations, insurance benefit coordination activities, insurer-provider relations, consumer education and outreach, fraud and abuse control, and rate setting. The Medicaid Management Information Systems represent a huge public investment in automatic data processing, and are continually modified to improve our capacity to pay claims efficiently and accurately, and to know what we are buying, from whom, and for whom. We do all this at an administrative cost, state and federal, that in fiscal 1991 was less than 4% of total Medicaid expenditures.

Under the administration's proposal the acute care services component of the Medicaid program would be folded into the universal system operated through the

alliances. The Medicaid programs would still operate a long-term care system and the children's "wrap around" benefit, but that would not consume all our existing staff and ADP capacity. Certainly some states will wish to use these to support alliance functions, as well as some of the state functions.

We also welcome the major role for the states because we know that what works for a lower-income population in Los Angeles does not necessarily work for one in south Florida or rural Appalachia. Provider practice patterns are different; so are consumer expectations. In Madison, Wisconsin managed care plans may be the norm; in other communities they don't even exist. State management can be more sensitive to local needs, particularly those of its lower-income population, than a highly centralized national or regional system of administration.

<u>Eligibility Determinations.</u> The administration's health care reform proposal would subsidize premiums and total out of pocket health costs for many lower-income Americans. The eligibility requirements are pretty simple: income ceilings, no asset limits, no complicated categorical requirements such as we have for Medicaid. Much of the necessary information would be supplied to the alliances (or whoever acts as their agents for this purpose) by the enrollees and other sources, such as state or county welfare offices. We would urge the Congress <u>not</u> to substitute for these provisions an elaborate,

and separate, eligibility structure such as exists now for Medicaid, AFDC, and food stamps. Let us not create another tangle of forms, requests for documents, delays, denials, and appeals.

Long-term care. I understand, Mr. Chairman, that you are planning another hearing that will focus on the long-term care components of the administration's proposal, so I will not comment on those except to note that we are generally supportive. The media has not given much publicity to the long-term care provisions contained in any of the national health reform proposals, yet it is probably in the long-term care area that many Americans feel most at risk. We look forward to appearing here before your Committee again to discuss this terribly important part of any comprehensive health care reform.

Thank you.

Mr. WAXMAN. Ms. Riley.

STATEMENT OF IRENE RILEY

Ms. RILEY. Thank you. On behalf of the National Association of Counties, Los Angeles County Department of Health Services, our director, Robert Gates, and to a small extent, American Airlines, and their strike of the flight attendants, because that is why I am here, I am grateful for this opportunity this afternoon to address you.

I would like to thank you, Mr. Chairman, for your continued support of Medicaid and other indigent health care programs, and I would like to express my thanks to Congressman Moorhead for his concern and support for Los Angeles County Department of Health Services.

I speak this afternoon from a provider standpoint. The issue with county health providers is survival. Whether it be in Los Angeles, New York City, Dade County, Chicago, Houston, Dallas, or Cleveland, the major county health providers are concerned about their future role under health care reform.

In the past 2 months, I have been repeatedly asked by reporters one question over and over again, what is the role for county health in the future? Who needs county health services anymore? Basically, everyone is going to have a Health Security Card. All medical care will be paid for, so why do we need county health anymore? We can close all the county hospitals and save all this money.

I think that question stems from basic misunderstanding of what the county's health care role is in a community. For example, in Los Angeles County, we have 6 hospitals, 39 health centers, and 6 comprehensive health centers. We provide over 4 million outpatient visits a year. We provide one-half of the trauma care in Los Angeles County. We serve all county residents. We have the only jail ward; we have one of the only two burn wards; we have the largest outpatient AIDS clinic in Los Angeles County; we have the only long-term care facility for the severely disabled.

The majority of Medicaid prenatal services are provided by county health services. One of our hospitals, our obstetrical hospitals, women's hospital, the births in that hospital, 1 out of every 200 births in the United States are there in Los Angeles County. The basic misunderstanding there is not simply with what services are provided, but whom do we provide these services to?

Our patient population in Los Angeles County—and it is not necessarily the same I understand for all county facilities—but in our county facility, over half of our $2.2 billion funding is from the Medicaid program.

The people to whom we provide services are the poor and the indigent persons. Over 60 percent of our population is foreign-born. There are 72 different—talk about culturally sensitive—there are 72 languages spoken in Los Angeles County.

The understanding has to come that county hospitals provide a traditional, ongoing role in the community. They provide a roll that is not easily going to be picked up by managed competition or high-rise HMO's. They also provide a service to a group of persons that not necessarily are going to be some of the ones that HMO's are necessarily beating down the door to get into their HMO.

Our concerns are about the future, about survival. As a provider, we are also concerned that we are not being actively sought as county health providers into the planning process. We want to be involved at the administration level and also at the provider level, because who knows best this population that is now being spotlighted, that is now being focused on, not only on a national level but particularly in committees such as these.

We want more participation in the alliance setup. For example, the State of California in a hearing just last Wednesday at one of our hospitals, as a matter of fact, a State conference committee is thinking about having only one alliance, since the States have flexibility, for the entire State of California. Los Angeles has 9 million people in it alone and serves a unique population where 2.7 million are uninsured and 1.6 million people are on Medicaid today in Los Angeles County; that is, nearly half the county population is either poor or on Medicaid.

We would like protection during the transition period and we would like to be involved in the planning process and work in setting up alliances.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Riley follows:]

STATEMENT OF NATIONAL ASSOCIATION OF COUNTIES

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, I AM ROBERT GATES, DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES FOR THE COUNTY OF LOS ANGELES. I AM TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES* AND APPRECIATE THIS OPPORTUNITY.

COUNTY GOVERNMENTS WELCOME THE HEALTH REFORM DEBATE. COUNTIES ARE OFTEN THE SERVICES SAFETY NET AND ARE INCREASINGLY THE FEDERAL AND STATE FISCAL SAFETY VALVE. COUNTIES HAVE THE LEGAL RESPONSIBILITY FOR INDIGENT CARE IN OVER 30 STATES AND IN OVER TWENTY STATES THEY PAY A PORTION OF THE NON-FEDERAL SHARE OF MEDICAID. I HAVE ATTACHED TO MY TESTIMONY A FACT SHEET ON COUNTY MEDICAID PARTICIPATION.

MY TESTIMONY WILL FOCUS ON THE COUNTY ROLE IN PROVIDING HEALTH TO THE UNINSURED AND MEDICAID POPULATIONS. I WILL ADDRESS ESSENTIAL COMMUNITY PROVIDER STATUS, DISPROPORTIONATE SHARE PAYMENTS, UNDOCUMENTED IMMIGRANTS, ENABLING SERVICES, PUBLIC HEALTH AND SUBSIDIES.

THESE ISSUES ARE CRITICAL FOR LOS ANGELES COUNTY. WE HAVE THE HIGHEST UNINSURED POPULATION RATE IN THE NATION, NEARLY HALF OF THE SIX MILLION UNINSURED IN CALIFORNIA RESIDE IN LOS ANGE~~LES AND IT HAS~~ MORE THAN

* The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

DOUBLED IN THE LAST DECADE. OUR SYSTEM IS OPERATING ON A BUDGET OF OVER $2.17 BILLION. ONLY ONE PERCENT OF THE REVENUES ARE FROM PRIVATE INSURANCE. FORTY-NINE PERCENT OF OUR REVENUES ARE FROM MEDI-CAL (MEDICAID).

MANY OF OUR PATIENTS ARE NOT ACCEPTED BY NON-PROFIT OR PRIVATE HOSPITALS. WE TREAT GUNSHOT AND STABBING VICTIMS, PERSONS WITH AIDS, THE HOMELESS AND OTHER DIFFICULT TO SERVE POPULATIONS. OUR MLK/DREW MEDICAL CENTER HAS A MILITARY TRAINING CONTRACT DUE TO ITS SIMILARITY TO BATTLEFIELD CONDITIONS.

ESSENTIAL COMMUNITY PROVIDERS

WE ARE PLEASED THAT THE CONCEPT OF ESSENTIAL COMMUNITY PROVIDER IS INCLUDED IN THE LEGISLATION BUT ARE TROUBLED BY THE LACK OF SPECIFICITY FOR COUNTY FACILITY ELIGIBILITY. CLARIFYING ECP ELIGIBILITY WILL BE CRITICAL TO LOS ANGELES COUNTY WHERE OVER $544 MILLION WAS PROVIDED LAST YEAR IN UNCOMPENSATED CARE BY OUR SIX PUBLIC HOSPITALS, SIX COMPREHENSIVE HEALTH CENTERS AND 40 PUBLIC HEALTH CENTERS.

UNDER THE PRESIDENT'S PROPOSAL, AUTOMATIC DESIGNATION IS GIVEN TO CERTAIN RECIPIENTS OF FEDERAL DISCRETIONARY HEALTH FUNDS. SINCE MOST LOCAL PUBLIC HEALTH DEPARTMENTS RECEIVE MATERNAL AND CHILD HEALTH OR RYAN WHITE AIDS FUNDS, WE ASSUME THAT MANY OF THEM WILL RECEIVE AUTOMATIC FEDERAL DESIGNATION. LEFT UNCLEAR IS WHETHER THAT SPECIFIC PROGRAM WOULD BE DESIGNATED OR THE ENTIRE FACILITY. IN ORDER TO PRESERVE CONTINUITY OF CARE, WE BELIEVE THE ENTIRE FACILITY SHOULD BE DESIGNATED.

MORE TROUBLESOME IS THE LACK OF ANY PUBLIC HOSPITAL RECEIVING AUTOMATIC ECP STATUS. CLEARLY, PUBLIC HOSPITALS ARE IN THE BUSINESS OF SERVING THE UNINSURED. NACo AND LOS ANGELES COUNTY WILL WORK TO ENSURE THAT THE ESSENTIAL COMMUNITY PROVIDER STATUS IS STRENGTHENED TO INCLUDE SPECIFIC MEASURES SUCH AS THE PERCENTAGE OF LOW-INCOME PERSONS SERVED BY A FACILITY. THAT TYPE OF PROVISION WILL MAKE ECP STATUS FOR A PUBLIC HOSPITAL MORE CLEAR THAN THE RECEIPT OF FEDERAL DISCRETIONARY FUNDS. WE ARE CONCERNED THAT WITHOUT ADDITIONAL STATUTORY GUIDANCE, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES MAY CHOOSE TO RELY UPON A HEALTH PLAN'S UNPROVEN TRACK RECORD IN PROVIDING CARE TO THE POOR.

SOME MAY ARGUE THAT THIS IS A COUNTY "TURF" ISSUE. IT IS NOT. A TRULY REFORMED SYSTEM SHOULD NOT RE-CREATE A TWO-TIER DELIVERY SYSTEM. UNDER A CAPITATED PAYMENT, HEALTH PLANS HAVE LITTLE INCENTIVE TO REIMBURSE PROVIDERS THAT THEY HAVE NO CONTRACTUAL OBLIGATION WITH. ACCESS TO UNIVERSAL COVERAGE MUST BE ACCOMPLISHED AND A SHORT-TERM, SPECIAL STATUS WILL HELP ACCOMPLISH THAT PRINCIPLE. WE SUPPORT THE ESSENTIAL COMMUNITY PROVIDER STATUS THROUGH THE TRANSITION TO UNIVERSAL COVERAGE.

MEDICAID DISPROPORTIONATE SHARE FUNDING

RELATED TO THE COMMUNITY PROVIDER ISSUE IS THE CURRENT DISPROPORTIONATE SHARE PAYMENT PROGRAM. THE HEALTH SECURITY ACT ELIMINATES, WITH ONE EXCEPTION, THE MEDICALLY NEEDY CATEGORY OF MEDICAID BENEFICIARIES. THE ELIMINATION OF THIS MEDICAID CATEGORY IS PREMISED ON THE BASIS THAT THESE BENEFICIARIES ARE EMPLOYED. BY REQUIRING EMPLOYER MANDATES, THESE INDIVIDUALS WILL BE PROVIDED HEALTH CARE THROUGH THE ALLIANCES AND WILL NOT NEED MEDICAID.

NOT ALL PERSONS WHO NOW RECEIVE MEDICALLY NEEDY MEDICAID ARE EMPLOYED. SOME OF THESE MEDICAID RECIPIENTS DO NOT QUALIFY FOR CASH ASSISTANCE FOR REASONS OTHER THAN INCOME FROM EARNINGS THROUGH EMPLOYMENT.

THE ELIMINATION OF THIS MEDICAID CATEGORY WILL GREATLY REDUCE OUR INPATIENT MEDICAID DAYS AND HAVE A DIRECT, IMMEDIATE EFFECT UPON DISPROPORTIONATE SHARE (DSH) PAYMENTS. THERE WILL ALSO BE A DIRECT, IMMEDIATE NEGATIVE EFFECT UPON THE EMPLOYMENT STATUS OF OUR HOSPITAL MEDICAID WORKERS.

UNDER THE HEALTH SECURITY ACT, HOSPITALS AND OTHER PROVIDERS WILL RECEIVE INSURANCE PAYMENTS FOR ALL LEGAL RESIDENTS. CONSEQUENTLY, THE PROPOSAL ASSUMES THE ELIMINATION OF DSH PAYMENTS.

NACo AND LOS ANGELES COUNTY WILL WORK TO ENSURE THAT THIS PHASE OUT IS NOT PREMATURE. TO THE EXTENT NOT ALL PERSONS ARE COVERED ALL OF THE TIME, THERE WILL CONTINUE TO BE UNREIMBURSED COSTS TO THE COUNTY.

WE WOULD LIKE TO SEE DISPROPORTIONATE FUNDING CONTINUE FOR THESE UNREIMBURSED COSTS. WE WOULD ALSO LIKE TO HAVE A GUARANTEE THAT THE PAYMENTS WILL CONTINUE THROUGH THE PHASE-IN PERIOD, OR AT LEAST UNTIL JANUARY 1, 1998.

UNDOCUMENTED ALIENS

UNDER THE CLINTON PLAN, UNDOCUMENTED ALIENS WILL NOT BE ENTITLED TO THE GUARANTEED BENEFIT PACKAGE. UNDOCUMENTED ALIENS WILL, HOWEVER, CONTINUE TO BE ELIGIBLE FOR MEDI-CAL (MEDICAID) FOR EMERGENCY SERVICES. BECAUSE THEY WILL NOT RECEIVE THE GUARANTEED BENEFIT PACKAGE, UNDOCUMENTED ALIENS WILL NOT BE COVERED FOR PREVENTIVE-TYPE CARE, THE USE OF WHICH TENDS TO REDUCE THE NEED FOR MORE COSTLY EMERGENCY ROOM CARE. AS OF 1990, APPROXIMATELY 700,000 UNDOCUMENTED ALIENS RESIDE IN LOS ANGELES COUNTY. WE ESTIMATE THAT NEARLY 25 PERCENT OF OUR PATIENT POPULATION IS UNDOCUMENTED, INCURRING AN ANNUAL NET COST OF $159 MILLION. ALTHOUGH WE UNDERSTAND THAT THE PLAN HAS IDENTIFIED RESIDUAL DSH MONIES TO REIMBURSE FACILITIES SUCH AS OURS, THE AMOUNT IS INSUFFICIENT.

WE WOULD LIKE TO SEE THE PLAN PROVIDE SPECIFIC REIMBURSEMENT FOR NON-EMERGENCY (OTHERWISE UNREIMBURSABLE) COSTS INCURRED IN PROVIDING HEALTH CARE TO UNDOCUMENTED ALIENS.

ENABLING SERVICES

WE KNOW FROM EXPERIENCE THAT MANY OF THE COUNTY RESIDENTS WE SERVE MUST OVERCOME NON-MEDICAL BARRIERS BEFORE THEY GET PROPER HEALTH SERVICES. WE ARE EXAMINING CLOSELY PROVISIONS IN THE LEGISLATION TO REACH OUT AND SERVE THESE POPULATIONS.

COUNTIES ARE CONCERNED ABOUT THE PERMISSIVE LANGUAGE GIVING STATES THE OPTION TO PROVIDE FISCAL INCENTIVES TO HEALTH PLANS TO ENROLL AND SERVE DISADVANTAGED GROUPS. STATES ALSO HAVE AN OPTION TO PROVIDE FUNDS FOR

EXTRA NON-MEDICAL SERVICES TO ENSURE ACCESS SUCH AS OUTREACH, TRANSPORTATION AND INTERPRETING SERVICES.

IN ANOTHER SECTION OF THE BILL, THERE ARE AUTHORIZATIONS UNDER THE PUBLIC HEALTH SERVICE INITIATIVE TO SUPPORT ENABLING SERVICES AND TO CREATE PUBLIC OR NON-PROFIT HEALTH PLANS WHICH SERVE SIGNIFICANT NUMBERS OF THE MEDICALLY UNDERSERVED.

SINCE WE SEE THE CURRENT SYSTEM DISARRAY AT THE LOCAL LEVEL, WE BELIEVE THAT THERE IS A POTENTIAL FOR FAILING TO REACH DISADVANTAGED POPULATIONS UNDER THIS DESIGN. STATES WILL BE UNDER TREMENDOUS PRESSURE TO FULFILL THE NEW REQUIREMENTS OF THE SYSTEM. IT IS UNLIKELY THAT THEY WILL ACT ON AN OPTION TO PROVIDE ENABLING SERVICES SINCE THEY WILL ASSUME A SEPARATE POOL OF FEDERAL MONEY MAY BE AVAILABLE UNDER THE PUBLIC HEALTH INITIATIVE , OR, AS A LAST RESORT, COUNTIES WILL FILL IN THE GAPS.

THERE MUST BE GREATER ASSURANCES THAT ENABLING SERVICES FUNDS WILL BE AVAILABLE TO HEALTH PLANS OR ESSENTIAL COMMUNITY PROVIDERS. THE CURRENT STATE OPTION AND A POSSIBLE FEDERAL APPROPRIATION LEAVE TOO MANY CHANCES FOR FAILURE. PERHAPS A SPECIFIC SET-ASIDE WITHIN THE REGIONAL ALLIANCES WOULD GIVE GREATER CERTAINTY THAT THESE CRITICAL SERVICES ARE PROVIDED.

PUBLIC HEALTH INITIATIVES

THE PRESIDENT'S PUBLIC HEALTH INITIATIVES ARE A STRONG STEP IN THE RIGHT DIRECTION. NACo SUPPORTS ATTENTION TO CORE PUBLIC HEALTH FUNCTIONS AND TO SPECIFIC HEALTH PROBLEMS OF A REGIONAL OR NATIONAL SIGNIFICANCE. HOWEVER,

WE HAVE CONCERNS OVER THE PROPOSAL'S FRAMEWORK. FIRST, THE ENTIRE INITIATIVE IS SUBJECT TO APPROPRIATIONS, LEAVING STATES AND COUNTIES WITH NO ASSURANCES THAT THESE CRITICAL PREVENTION AND PUBLIC HEALTH ACTIVITIES WILL INDEED BE FUNDED. SECOND, UNDER THE COMPETITIVE GRANT PROCESS FOR THE CORE PUBLIC HEALTH INITIATIVE, STATES MUST ASSURE THAT STATE AND COUNTY FUNDING WILL BE MAINTAINED. HOWEVER, THERE IS NO FORMAL COUNTY ROLE UNDER THE STATE APPLICATION PROCESS. IF STATES CAN USE COUNTY TAXPAYER DOLLARS, THEN COUNTIES MUST BE INVOLVED IN THE GRANT APPLICATION.

LOW INCOME SUBSIDIES

FINALLY, I KNOW THERE IS CONCERN OVER WHAT HAPPENS IF THE SUBSIDY FUNDING FOR LOW INCOME POPULATIONS IS DEPLETED. WHO WILL THEN HELP PAY FOR THEIR HEALTH SECURITY? IF CONGRESS DOES NOT TAKE ACTION, COUNTIES WILL ULTIMATELY BE THE LEVEL OF GOVERNMENT TO PICK UP THE PIECES. STATES ARE NOT GOING TO REPEAL THEIR INDIGENT CARE LAWS IN THOSE THIRTY STATES WHERE COUNTIES HAVE THAT RESPONSIBILITY.

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY. I WILL BE HAPPY TO ANSWER ANY QUESTIONS.

Mr. WAXMAN. Thank you very much for your testimony.

Let me ask each of you for the record to clarify—does your organization endorse President Clinton's Health Security Act, not the principles, but the bill?

Mr. Volpe?

Mr. VOLPE. The organization takes no formal position on the bill but will take positions on aspects of it.

Ms. SCHWARTZ. This also doesn't sound like that kind of answer. We have not taken an absolute yea or nay, we like it or don't like it, but I think there are many aspects of the plan we are excited about and areas we have some problems with. With that, we are looking forward to working it out and making it happen.

It is NCSL's position that we want to move comprehensive health care reform along but, in the process, want to work with you to make that happen. I would be hard-pressed to say I like every line on it, but we have not endorsed the President's plan.

Mr. WAXMAN. I endorse it and I don't like every line.

Mr. Hanley.

Mr. HANLEY. We support aspects of it, certainly, and we commend the President for pushing the issue to the forefront but are not prepared at this time to endorse his plan or anybody's specifically.

Ms. RILEY. On behalf of the general principles which you don't want to hear, we support it. And NACO, I would have to check on that.

Mr. WAXMAN. What if we do not enact health care reform next year, not the President's bill, not some other bill, and we are left with the status quo including the ERISA preemption of States' efforts to tax or regulate self-insured plans?

What do you think States will do to their Medicaid programs? Will they go down the Oregon rationing trail; will they take the Tennessee approach of massive forced enrollment into managed care plans, serving only the poor; or will they simply start cutting back on eligibility benefits and reimbursement?

Mr. Volpe, why don't we start with you?

Mr. VOLPE. It is hard to know, Mr. Chairman, quite honestly. My sense is that—one thing I can say for sure is, I think they will be looking at managed care strategies, not necessarily attended care approach but a managed care strategy to try in the interim to get control of their costs.

Some States are looking at a more comprehensive approach like a Tennessee or a Rhode Island or a Hawaii, but I am not sure how many are planning to submit those kinds of waivers. I don't know of many who are looking at the Oregon approach, quite honestly. I think you will see a lot of States looking to try to move towards managed care under the managed care waiver approach.

Ms. SCHWARTZ. I basically agree. I think it will depend State by State on the orientation of both the legislature and the Governors. I think the move towards managed care is where we are headed. I think in Pennsylvania, we have learned a bit about the need to merge provider systems and make sure that enrollees in fact are not segregated; that if we are interested in both cost containment and good quality health services to everyone, that we need to look at managed care, the good vehicle.

We have actually seen some real savings in Pennsylvania. We pay 87 percent of the fee-for-service dollars to managed care for medical assistance recipients. So right off the bat, we know we are saving real dollars and in some cases people are getting better services, not all cases. But we are moving with our most recent waiver to the Federal Government to have a commercial piece in every Medicaid HMO so that we are looking at at least 25 percent of every managed care network even for Medicaid has to be a commercial population.

We are looking at merging the populations in managed care and are seeing the natural forces in the private sector moving towards network of providers across hospitals, across physicians' groups. We are seeing a pretty dynamic process in the health care system both in the public and private sector, potentially as a merger.

Mr. HANLEY. Medicaid is going to continue to move toward managed care no matter what happens next year and there is going to be a lot of State-based health care reform. If you are concerned, you will end up with HMO's or managed care with Medicaid only, I think there are signs that won't happen.

In our State, we passed legislation last year to give us the right to merge Medicaid State employees and teachers in one group. We are seriously looking at that. The States of Oklahoma and Kentucky are looking at that. I think you will see a lot of that merger that the Senator talked about occurring, market forces are causing that as well as just the idea that the alliance. The more people you can pool together, the better deal you can cut when you go to buy insurance or health care.

Ms. RILEY. If California follows true to form, California's big concern will be from a fiscal standpoint. What California would do and what I would do is I would cut. I would try and cut as many optional benefits as possible. I would try to reduce my State care as much as possible because, under health care reform—and it is going come sooner or later—there is a maintenance of effort requirement, OK? They are going to argue, all the State people will argue with me. I can handle that. That is one thing.

The other thing I think California will do is to continue on this very, very aggressive roll into managed care. It could even be by default that persons are into managed care as opposed to fee-for-service.

Mr. WAXMAN. Let me ask you a question about this maintenance of effort. The President's plan requires States to make maintenance of effort payments to regional alliances on behalf of current Medicaid beneficiaries who do not receive cash assistance. These State payments are crucial to the financing of the President's plan accounting for $74.9 billion over 5 years or one-fifth of total financing for the plan. These maintenance of effort obligations are based on current Medicare spending patterns and current matching rates.

Mr. Volpe, you testified that this strategy could punish States with more generous programs by requiring of them a great financial maintenance of effort. Senator Schwartz, you testified that this requirement penalizes States that made the greatest effort to expand Medicaid coverage over the last several years.

Mr. Volpe, can you tell us specifically which States could be punished? And Senator Schwartz, can you tell us specifically which States would be penalized?

Mr. VOLPE. I can comment only on one State that has spoken to me about it directly, the State of Wisconsin. They have repeatedly talked about their benefits package and their concern for a greater maintenance of effort. That is why the association says that we are interested in the commission to try to look at the possibilities of perceived inequities among the States to correct that kind of a problem.

Ms. SCHWARTZ. I believe that we could give you information, about which States provide more optional services and which ones have opted to increase eligibility limits. That information is available. We would be happy to provide that to you.

What has been more difficult for us to figure out is, each State is trying to do this, is to figure out going through the entire plan, where are there savings or where are there expenditures that we might have to maintain? So it has not been an obvious win/lose situation. I think that is the reason we are willing to be somewhat flexible in this discussion.

We do recognize that there is an attempt in the plan to say, here you have to pay 95 percent here, you don't have to pay any more here; you do. It is not looking at just one element of the plan around maintenance of effort. It is a concern of ours that in Pennsylvania we have been fairly generous in our benefits. I think although we are being pushed by some to reduce those benefits, we don't want to reduce benefits. So we are not inclined to say we want to reduce those benefits.

But we also recognize that—we feel that there should be some fairness across the board for Americans. So it is not only what State you live in, it is really as an American you have access to these services, and some more universal approach to that is one that we are all endorsing.

Mr. HANLEY. I think Ms. Riley's concern about they will cut benefits lower than maintenance of effort, the reason I don't think that will happen because, in the bill, the base year is already passed. It was 1993. So there is nothing to be gained as far as having a lower maintenance effort in the future to cut benefits henceforward.

Mr. WAXMAN. The President's plan would phase out Medicaid payment adjustments to disproportionate share hospitals saving $54.5 billion over 5 years to help finance health care reform. In its place, the President proposes a new entitlement program of payments to hospitals serving vulnerable populations capped at $800 million per year.

Of this amount, 25 percent or $200 million per year would be available for hospitals providing inpatient services to illegal immigrants. In contrast, the President's plan would withhold $58 billion over 5 years for deficit reduction.

Ms. Riley, you testified that in L.A. County alone your annual net cost of treating the undocumented is $159 million. Under the President's plan, if your costs were fully covered, only $40 million would be left for the rest of the country. Obviously that is not enough.

What amount do you believe should be set aside for counties and other facilities serving high volumes of illegal immigrants?

Ms. RILEY. The $159 million is 2 years old. So just based on growth, we could probably suck up all the money, the $200 million easily. And, truthfully, I am not familiar with other areas of the United States except to the extent that I know on the Census from 1990, Los Angeles County had the most growth and has the largest population of foreign-born population in the United States, which in fact L.A. County's foreign-born population is larger than the entire State of New York.

I am not—you are asking the wrong person here because I believe for Los Angeles County—and I am a strong advocate of universal health care means universal health care—and I basically feel that what will happen by segmenting out a portion of the patient population that is a part of the community and lives and resides within the United States, that both the Federal Government has recognized lives there and has no intention of picking them up and putting them back. We are talking between 700,000 and a million persons in Los Angeles County alone.

I am not so sure that these people shouldn't be covered in a preventive primary care, thoughtful way as opposed to just dealing with the emergency issue. I don't know what the figure is, but I think $200 million is definitely insufficient.

Mr. WAXMAN. We need to get some figure on what it is going to cost, so I would like to ask the National Association of Counties or any other organizations, any other groups here, to see if you can give us your best estimates as to what amount of money is going to be needed to meet this very definite need.

Ms. SCHWARTZ. If I may, I would be happy to ask NCSL to work on that. A piece of my testimony that I didn't have time to give orally speaks to the need we have on the part of the States to have this responsibility picked up by the Federal Government and to assist States that are serving this population.

I agree that for us not to be shortsighted about agreeing to pay for emergency room and hospital care, having just learned from the experience under medical assistance we have been talking about it, of the need to provide primary care and prevention as a way of long-term savings, we will just be repeating an experience we have just had, and we ought to start out doing it the right way this time if we can.

Mr. WAXMAN. Thank you.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. I have to run, so I will let you ask questions and then conclude the meeting. Thank you all very much.

Mr. BROWN [presiding]. You mentioned the Pennsylvania CHIP program. Tell us—you have said more negative about it than you did positive—but elaborate on some of its successes and a little more detail about the problems it had with its sort of elaborate set of eligibility criteria if you would.

Ms. SCHWARTZ. I am sorry to have given a negative impression. The program is pretty new and I personally worked hard to get it there so I don't want to give a totally negative impression of it.

What we have done is this has only been implemented for 6 months. We have dedicated 2 cents of the cigarette tax producing $20 million in Pennsylvania geared towards those children 0 to 6 who are at 185 percent of poverty and then 6 through 18 who are at 100 percent of poverty. We geared it mostly to very young children and also to the poorer children through age 18.

The issue here is that it really speaks to the fragmented health care system that we are trying to address in health care reform, which is that you need to find the parents of those children, get the enrollment forms to them and sign them off. It has been—we have actually subcontracted with private insurance carriers, U.S. health care and Blue Cross-Blue Shield in Pennsylvania.

Because of their orientation to commercial enrollees, they have not had an easy time in reaching out to poorer, low-income people. There are people working in low-income communities that are very frustrated that they know how to do outreach, need to do grassroots, door-to-door outreach, need to get people where they are—they don't read the ads in the newspaper, they don't necessarily have the literacy to do the enrollment forms on their own, and we are now trying to increase outreach to make sure kids know about it.

We have enrolled under—I think, just under 10,000 children. We could enroll 40,000. We hope to get closer to that by the end of the year. We have found, I think it is about 3 to 1, that the children who call are not eligible for this particular program although they don't have health insurance coverage. It is interesting that there are a number of parents who call to find out about the program but in fact don't meet these particular eligibility guidelines.

Mr. BROWN. How will you go from 10,000 to 40,000? What changes are you going to make?

Ms. SCHWARTZ. Some of that will be increasing outreach in a much more grass roots way rather than through ads in newspapers and through commercial marketers. Exactly how we will do that, we are working on now. Some is also working through some of the natural resources and use some of the data we have about enrollment.

We would like to see county assistance people enrolled, people in CHIP. We haven't done that yet. We need to enroll people in a variety of programs. That hasn't happened yet. We are looking at those things in addition to the possibility of changing some of the eligibility criteria for next year.

Mr. BROWN. What can we learn in our health plan from CHIP?

Ms. SCHWARTZ. The simplest thing is that in the bill—the way it is written now—there are different eligibilities for different ages. I think that the simplest thing to do is to say all children at this income level are eligible so that it doesn't matter if you are 6, 7, 8 or 9, you will be eligible for the program, to simplify it. You make sure that every plan is a provider of those services so that you don't then have to go out and find a different provider, but every provider of children's services is also a provider of these children's services.

It suggests in the bill otherwise, that the children would have to go to essential community providers. They shouldn't have to. Everyone should be able to provide those services to children. I be-

lieve that if they are not signed up, I believe that eligibility determination should be made when they are signed up, when the family is signed up and they don't have to do any separate application process.

Those three points, I think, would eliminate some of the difficulties the way it is written now.

Mr. BROWN. The Clinton health plan seems to provide good universal coverage on paper. Are we able here and are the States able to do the kinds of outreach programs, particularly with prenatal care and immunization, and really make a big, big difference? Does CHIP tell you that we are able to do that nationally?

Ms. SCHWARTZ. Not only CHIP, but some of the other experiences like Healthy Beginnings Plus and a variety of programs that we have had to enhance prenatal services, where we find the outreach piece is as important as the coverage.

A couple of things. Most specific is that just coverage alone doesn't do it. You can get one of those health care cards, but as the previous panel talked about, unless you make sure services are accessible and attractive—by including cultural sensitivity in that attractiveness, people will access them and they are available in our neighborhoods. It is not enough to just get coverage.

Second, I would say—I am taking less of a position of NCSL than my own—I believe we ought to get away from eligibility determination as much as possible. I think the degree the States would have flexibility, for example, to make assessments about the populations that are being served by those plans and make estimates on that basis to provide services that are needed for those populations rather than individual specific eligibility, we would do a lot better.

Let me say if I can in this way: In other words, if we say that children need these services, children who needed the EPSDT services—probably most children need those services. We are gearing it mostly towards low income, but we ought to say—there are about—I think we could do this now. We have this information.

There are about 10,000 of those children in southeastern Pennsylvania for example. Let's increase the per capita payment to all the networks by $3 and make sure those services are available to all those children. Otherwise, we will spend a whole lot of money on paperwork, eligibility and outreach when in fact we could be spending the money on services. It is a risk, I suppose; it trusts the system a little bit, but I think it is the way we ought to go.

Mr. BROWN. Would you be willing to put some of your thoughts in making that happen with outreach on paper and any thoughts from other people through NCSL what other States have done that might be useful to us in that way?

Ms. SCHWARTZ. I would be happy to.

Mr. BROWN. Thank you all for being here. I appreciate, especially Ms. Riley, your coming on very short notice. Thanks to all of you.

We are adjourned.

[Whereupon, at 3:05 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted:]

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Statement for the Record
of the
American Hospital Association
before the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
on
Impact of Health Care Reform on Medicaid Beneficiaries
and Other Low-Income People

November 19, 1993

The American Hospital Association (AHA), representing nearly 5,000 hospitals and health care organizations across America, respectfully submits this statement for the hearing record of November 19, 1993. The AHA is grateful for the leadership of this subcommittee and particularly its chairman, Mr. Waxman, in expanding and improving the Medicaid program over the years to help the most vulnerable of our society. We are especially grateful for the recognition by the subcommittee of the special role many hospitals play in serving this population group and for the help provided those hospitals. Health care reform offers us a once-in-a-lifetime opportunity to extend and improve health care coverage for all Americans, particularly our most vulnerable.

AHA salutes President Clinton and the First Lady for their significant work in nurturing the current reform climate. America's hospitals, through AHA, have worked for more than two years to shape our own blueprint for health care reform; we are very pleased that the President's plan shares many of our building blocks. For purposes of this statement, our comments will address those features of the Administration's plan that are relevant to the focus of this hearing.

Universal Access

We share the President's belief that any reform plan must move us as quickly as possible to health coverage for all. Universal access and coverage for basic care is at the top of AHA's list. This is a non-negotiable item, not only because it is the morally

right thing to do, but also because without universal coverage health care reform simply doesn't work -- without it, providers must continue to shift costs from the uninsured to the privately insured, undermining our goal of moderating rising health costs.

Medicaid

As we continue to review the specific details of the President's Medicaid proposal, we are encouraged by the President's goal of rapidly integrating Medicaid acute care services into the new health care system. AHA believes that it is essential that providers' incentives should be the same, no matter who sponsors a patient's care, to promote the most appropriate and cost-effective care.

While AHA supports the goal of integrating Medicaid services into a reformed health system, we believe any plan to do so must have an adequate funding mechanism that enables providers to deliver quality health care to all individuals, regardless of the source of their health care premiums. Payments to regional health alliances and, in turn, to health plans, must be adequate to cover the cost of delivering promised services and include the establishment of adequate risk adjustments for this population. Given these concerns regarding the adequacy of funding, careful attention needs to be given to the following: the establishment of the base year for determining the state per capita payment and maintenance of effort payments; the adequacy of the state per capita payment that is equal to 95 percent of the state's Medicaid spending; and the determination of the state's maintenance of effort payment. In particular the termination of current "Boren Amendment" protections merits review in the context of adequately funding alliances and health care plans.

The proposal to phase out the Medicaid Disproportionate Share Hospital (DSH) payment program also deserves careful attention. The program's historical purpose was to compensate hospitals for the higher costs of treating low-income patients, and to assist financially distressed hospitals serving large numbers of low-income patients to assure those patients access to needed care. The necessity of a DSH payment may diminish as health care coverage through universal access increases. But as states move their Medicaid populations into the new health care system, any plan to phase out Medicaid DSH payments must provide the necessary assistance to hospitals until all low-income individuals are fully integrated into the new heath care system. The Administration does not provide for a smooth transition -- a disconcerting gap of a year exists in the Administration's plan between when the Medicaid DSH program terminates and when states are required to come into full compliance. Safety-net hospitals would be asked to absorb an unacceptable burden created by a gap in payment as states move to universal access. It is these very institutions that will continue to provide care to the Medicaid and low-income population. These

instituions need all the resources available to them to survive a changing environment and can ill afford this additional financial burden.

Vulnerable Population Adjustment Program

We are encouraged that the Administration's proposal recognizes that hospitals will continue to deliver care that will be uncompensated by the reformed system. The Administration's new federally financed Vulnerable Population Adjustment Program is designed to address these uncompensated care costs. While we are continuing our review of this proposal, we would like to bring to the subcommittee's attention a number of initial concerns. First, it is not clear from the proposal how the payments are made to the designated hospitals. Are they made through the state or does the federal government make payment directly to the hospitals? AHA believes that payments should go directly to the provider. Second, there is some reasonable concern that the program's fixed authorization level may not be adequate to cover the yet unknown uncompensated care costs of these institutions. And third, we raise the general question of what role the state should play in administering the program. AHA believes that the state may play an appropriate role in helping determine eligible hospitals, particularly in identifying costs related to care provided undocumented aliens, but we would also argue that this role should be limited to an administrative one.

Public Health Initiatives

The President's reform plan allows for the designation of essential community providers to assure access and continuity of care in underserved areas during the first five years of reform. This provision will require health plans to contract with and reimburse established "essential community providers" in underserved areas. AHA believes hospitals should be included in the list of health care professionals and institutions eligible for designation as "essential community providers" by the Department of Health and Human Services. This will help essential community hospitals make the transition to the new health system without interrupting communities' access to necessary health services.

Structure of Health Plans

AHA also has concerns about the structure of the Administration's health plans. While they have shared characteristics with our vision of integrating care through community care networks[sm], they are by no means identical. The health plans must have a better-defined role set out at the national level, and more accountability

built in at the local level. AHA has real concerns that as currently defined they could harbor fly-by-night insurance schemes. It is of paramount importance for the Medicaid and low-income population that these plans have a sound basis. The way to address these concerns is to make sure health plans are under local governance; are targeted toward meeting local needs; and have a local accountability mechanism.

Conclusion

There are many other aspects of the Clinton plan that AHA is currently reviewing. These include: the size and role of the alliances; the process for seeking state waivers; the treatment of illegal aliens; the low income subsidy pool; and the special provisions extended to children from low-income families. AHA will continue to study these issues and looks forward to working with the subcommittee to find the best way to include them in comprehensive reform.

Hospitals pledge to play a constructive role in that process -- to work hard to support reform elements we believe build the right foundation, and to find agreement in those areas we now feel are not solidly grounded. As the American Hospital Association serves in that role, we don't see ourselves as advocates for the President's plan, the Conservative Democratic plan, the Senate Republican plan, for business or for labor. We see ourselves as advocates for the workable, good public policy.

The American Hospital Association looks forward to working with the subcommittee to reach our shared goal of better health care for all Americans.

The National Association of Children's Hospitals and Related Institutions, Inc.

Statement for the Hearing Record

"Impact of Health Care Reform
on Medicaid Beneficiaries and Other Low-Income People"

Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

Lawrence A. McAndrews, President and CEO
National Association of Children's Hospitals
and Related Institutions

The National Association of Children's Hospitals and Related Institutions (NACHRI) represents more than 130 institutions in the United States and Canada devoted to the delivery of care to the most vulnerable of children -- the poorest, the sickest, and those with specialized health care needs. On average, children's hospitals provide more than 44 percent of their care to children assisted by Medicaid.

Medicaid is the nation's largest and most important safety net for children's access to health care. Children constitute almost half of those living in poverty but, due to the recent expansions advanced by the Subcommittee, two-thirds of all poor children are now eligible for Medicaid, and they represent half of all Medicaid recipients. As such, great care should be given to how health care reform will impact Medicaid policies, both during a transition period and after full establishment of a new health care system, so that low-income children, hopefully, will have improved access to care but at the very least not be more disadvantaged than they are now.

NACHRI strongly supports President Clinton's leadership in making health care reform a national priority and his attention to the unique health care needs of children. We particularly support many of the principles we believe are fundamental to his health care reform initiative: universal coverage, comprehensive benefits, employer-based coverage, assurance of choice among health plans, recognition of the roles of essential providers of care to low income patients and academic health centers treating rare conditions, separating the financing of graduate medical education from patient care reimbursement, sustaining Medicaid eligible children's access to medically necessary care, and more.

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However, NACHRI believes the following issues would benefit from further consideration. Our comments are based on the October 27 draft of the President's legislation:

Children Should Have Access to Comprehensive Benefits Uniquely Tailored to Meet Their Needs The Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program offers the most comprehensive benefit package for children. Health care reform should assure that children, particularly those from low-income families, continue to have access to this full range of services. We are very pleased that the President's proposal seeks to address this important principle.

Under his October 27 draft legislation, states would provide cash assistance Medicaid children those Medicaid services not offered in the general benefit package; the federal government would be responsible for coverage of these same services for non-cash assistance Medicaid children. We are concerned that the federal program would appear to be structured as a capped entitlement and the long term state responsibilities are unclear. The provision of these necessary services to children whose families can ill afford to purchase them should be guaranteed, rather than conditioned on the changing availability of funding.

Children Should Have Access to Providers Best Suited to Meet Their Unique Health Care Needs Children's hospitals serving a disproportionate share of low income patients should be designated as essential providers, entitled to contract with plans, receive referrals and obtain minimum payment rates, in order to ensure continuing access for low income populations.

Health Care Reform Should Recognize the Special Requirements of Providers Serving a Disproportionate Share of Poor Children During the transition from Medicaid to a reformed health care system, disproportionate share hospital (DSH) payments and policies must be maintained. For children's hospitals, these DSH payment adjustments help cover the costs of care to Medicaid children since base Medicaid payment rates are severely inadequate. After the new system is established, the need for some type of disproportionate share payment adjustment will also be necessary. Low income populations will likely enroll in the low cost plans since cost sharing requirements will be minimal or eliminated. If Medicaid financing continues at historically inadequate levels, these health plans and the institutions that serve low income children will be at risk of inadequate financing to sustain their services.

Children's Access to Care Should be Well-Managed and Coordinated Low income children and families, least able to negotiate the complex maze of health system requirements, should

be assured easy access to both the general benefit package and the Medicaid wrap-around services. It is unclear how the states and the health plans will coordinate the provision of services for cash assistance Medicaid children and how the federal government will coordinate care with health plans on behalf of non-cash Medicaid children. Without care and detail in the design of a coordinated system of care, many children may be inadvertently denied needed services. In addition, any health plan that enrolls low income children should be required to demonstrate its ability to provide specially tailored services such as patient education in the use of the health plan and outreach and follow-up to ensure that children actually receive the preventive and primary care which can forestall the development of more serious conditions.

NACHRI applauds the Subcommittee for its past efforts in expanding access to health care through Medicaid for low-income individuals, particularly children, and its continuing focus on ensuring that health care reform serves the unique needs of low-income populations. NACHRI would be pleased to offer further details on these important issues and to work with the Subcommittee to safeguard low-income children's timely access to health care from appropriate providers.

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